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**Final Report of the Legislative Council
on the SJR 32 Study of
Medical Liability Insurance**

Rep. Kim Gillan, Presiding Officer
Sen. Bob Keenan, Vice Presiding Officer



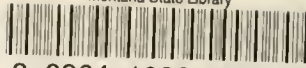
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September 17, 2004

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September 2004



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1. Beginning at the End

Background

Chapter 1 recapitulates the recommendations of the Legislative Council in response to the recommendations of the Council's SJR 32 Subcommittee on Medical Liability Insurance.

To set the context for the Council's action on September 17, 2004, including the four bills recommended by the Council to the 59th Legislature, the Council had created the Subcommittee in June 2003 for the sole purpose of conducting the study contemplated in Senate Joint Resolution No. 32 (2003). More specifically, SJR 32 requested a study of medical liability insurance issues that began to emerge during the 58th Legislative Session.¹ In a nutshell, the issues identified in and to be examined pursuant to SJR 32 included:

- the rising cost of liability insurance for health care providers;
- a significant decline in the past few years in the number of insurance carriers that provide liability insurance for hospitals, clinics, and nursing homes;
- the hypothesis that dramatic hikes in the prices paid by hospitals, clinics, and nursing homes for liability insurance may be a major contributor to the escalation in the cost of providing medical treatment;
- the theory that increased premiums for liability insurance may be forcing physicians and other providers in Montana to consider curtailing certain medical services;
- that the State of Montana has a compelling interest in ensuring that affordable health care is available for its citizens, and a contention

¹ In the poll of legislators used to determine the relative priorities of all of the studies requested by the 58th Legislature, SJR 32 was ranked the #1 priority.

that stabilizing premiums for liability insurance for health care facilities and health care providers associated with health care facilities will contribute toward cost containment for health care for Montana citizens.

The study committee was directed by SJR 32 to compile information seen to be relevant by the Legislature and to:

- review measures adopted by other states to address the liability insurance problems related to liability insurance for health care facilities and health care providers associated with health care facilities;
- identify or propose strategies for increasing the availability of affordable liability coverage, including alternative sources of liability coverage;
- identify factors affecting the cost of liability insurance for health care facilities and health care providers associated with health care facilities; and
- identify or develop strategies for resolving liability claims outside of the court system.

Introduction

In addition to regular updates at Legislative Council meetings by the Subcommittee's chair on the Subcommittee's progress, the Subcommittee submitted its final report² to the Council in September 2004. The thrust of the Subcommittee's final report was a package of eight recommendations, forwarded as draft legislation. The report also included background material considered by the Subcommittee during the interim that may have influenced the Subcommittee's recommendations.

At the September 17, 2004, meeting of the Legislative Council, Subcommittee Chair Rep. George Golie briefly reviewed the Subcommittee's

² The title of the Subcommittee's final report was also *Diagnosing the Ailment — Prescribing the Cure*, and it is available on the Subcommittee's website or through the Legislative Services Division, PO Box 201706, Helena, MT 59620-1706.

final report. The Subcommittee's staff described each of the Subcommittee's eight recommendations and responded to questions from Council members.

Subsequent to Rep. Golie's and the staff's briefings, Council Presiding Officer Rep. Kim Gillan solicited comments from the public, from other members of the Subcommittee, and from individuals referred to as "stakeholders" in the SJR 32 study, i.e., representatives of: insurers; doctors and other health care providers; hospitals and other health care facilities; and individuals commonly referred to as victims of medical negligence or malpractice. In response, the respective stakeholders addressed the Council with:

- uniform commendation of the Subcommittee's work in conducting the study; and
- a variety of concerns, questions, and suggestions; plus
- sometimes robust and sometimes lukewarm support for one or more of the Subcommittee's recommendations;
- a number of proposed amendments to one or more of the recommendations; or
- in some cases, outright opposition to one or more of the recommendations.³

Due in part to time constraints, the Council imposed a fairly confined time limit on stakeholders to make their comments. As a consequence, the stakeholders who testified on the Subcommittee's report and recommendations were compelled to distill many hours of description, illustration, case study, explanation, clarification, and nuance into about 90 minutes of commentary. For similar reasons, Council members, particularly those members who did not serve as members of the Subcommittee, were limited in their respective questions and any ensuing colloquy. Nevertheless,

³ For a more complete presentation of stakeholders' comments, see *Minutes*, Montana Legislative Council, September 17, 2004.

the Council waded through the Subcommittee's recommendations one by one, ultimately arriving at its own findings, conclusions, and recommendations.

Recommendations of the Legislative Council

The Legislative Council's recommendations are presented in this report before there is any narrative or documentation that might be construed as a finding or conclusion on which the recommendation is based. The purpose of this approach is to allow the reader to see "the bottom line" without having to sort through material that may or may not be of interest.

That said, however, the reader is strongly encouraged to read the entire report to gain a more complete appreciation of the information provided to and discussed by the Subcommittee and forwarded to the Legislative Council.

Recommendation 1: Tort Reform: LC 5001

This bill would revise the current status of general liability law, for purposes of a medical malpractice claim, to establish that medical liability may not be imposed on a health care provider for an act or omission by a person or entity claimed to have been an "ostensible agent" of the health care provider at the time that the act or omission occurred. This bill is intended to forestall what some stakeholders view as a possible misinterpretation or misapplication of the policy contained in 28-10-103, MCA. From testimony to the Subcommittee, many doctors who operate, make rounds, or otherwise provide medical services within a hospital, for example, are not employees of but do have "privileges" at the hospital. Under LC 5001, a nonemployee doctor is not an "agent"—ostensible or otherwise—of the hospital, and the lack of agency absolves the hospital from any

liability for an act of medical negligence or malpractice for which the doctor is responsible. The bill carves out for various health care providers a special immunity from certain liability.

Recommendation 2: Tort Reform: LC 5004

This bill was drafted to address what some stakeholders viewed as a misapplication of the "Captain of the Ship" legal doctrine. Some stakeholders proposed LC 5004 as a legislative response to the Supreme Court's decision in the *Rudeck* case.⁴ The bill achieves a similar objective as LC 5001, i.e., to ensure that only the *de facto* person or entity responsible for alleged medical malpractice is held liable for the malpractice. LC 5004 accomplishes the objective by creating a new section of law that, for purposes of a malpractice claim, immunizes a health care provider from liability for an act or omission by a person or entity that was not an employee or agent of or otherwise under the control of the health care provider at the time that the malpractice occurred. Notably, the new provisions are intended to be codified in Title 27, chapter 1, part 7, MCA, which is devoted to "Civil Liability, Remedies, and Limitations: Availability of Remedies -- Liability".

More than a stand-alone provision, LC 5004 combined with the effects of LC 5001 provide a "belt and suspenders" approach to immunizing health care providers from alleged and actual negligent acts of others who are not the providers' agents.

⁴ *Rudeck v. Wright*, 218 Mont. 41, 709 P.2d 621 (1985).

Recommendation 3: Tort Reform: LC 5005

This bill revises and clarifies the legal "loss of chance" doctrine as might be applicable under the *Aasheim* decision.⁵ Under *Aasheim*, if an injured person is injured further as a result of medical malpractice and the injured person's chance of recovery is further diminished as a result of the malpractice, the person is awarded the full amount of damages attributable to the malpractice *plus* the amount of damages due to the initial injury.

For example, let us assume that a person has injured her knee in an accident. As a result of the accident, she will have only a 50% chance of recovering her preaccident use of her knee. Rather than accepting even odds of full recovery, she chooses, knowing the associated risks of additional injury, to undergo orthopedic surgery to repair her injured knee. The surgery is not successful, the knee is not repaired, and her chance of recovering full use of the knee has declined to only 15%. She alleges malpractice and asks for damages of \$100,000. Under *Aasheim*, the damages payable to her are the entire \$100,000 determined for the loss of use of the knee—starting from the knee's condition prior to the accident.

In many other jurisdictions, the damages payable as a result of the malpractice would be only 35% of the amount determined for the loss of chance of recovery because her presurgery chance of recovery was only 50%. Therefore, in such jurisdictions and under the example, because the woman still has a 15% chance of recovery and because her chance of recovery prior to the surgery was only 50%, the damages assessable to the malpractice solely is 35% of the total damages.

⁵ *Aasheim v. Humberger*, 215 Mont. 127, 695 P.2d 824 (1985).

LC 5005 statutorily prescribes that calculation for damages for a "loss of chance". Under the bill, damages awarded must be the difference between the percentage chance of recovering prior to the malpractice (50% in the example) and the percentage chance of recovering after the malpractice (15%), multiplied by the total damages (\$100,000). Under LC 5005, the amount of damages payable would be \$35,000, i.e. 35% of the total damages.

Recommendation 4: Tort Reform: LC 5007

This bill establishes as a matter of state policy and the rules of evidence that an act of or words of benevolence from a medical provider cannot be used as evidence in a civil action for medical malpractice.

Testimony revealed that some medical providers, both individuals and institutions, often desire to express an apology, fault, sympathy, compassion, etc., for the pain, suffering, or death of a person in their care. However, in such instances health care providers are typically advised by legal counsel to refrain from such expressions for fear that the expression will be proffered as evidence of an admission of liability. This bill statutorily precludes expressions of sympathy, compassion, or benevolence from being admitted as evidence of admission of liability.

The Legislative Council members' rationale, as a group or as individuals, for the recommendations is not included as part of this discussion mainly because the rationale is unknown, perhaps even unknowable. Those who are familiar with the legislative process understand that it is foolhardy to speculate as to *why* any one legislator or group of legislators supports or opposes a policy, a bill, an amendment, or anything else on which a vote may be cast. However, reviewing information provided in the subsequent

chapters in this report and in the appendices that was available to the Council (albeit sometimes indirectly through the Subcommittee) may provide insight into the members' respective decisions.

Recapitulation of the Council's Recommendations

The Legislative Council determined that revising various tort laws was in the interest of Montana.⁶ Consequently, the Council recommends LCs 5001, 5004, 5005, and 5007. (See Appendix A.) Respectively, the four bills revise or establish statutes that:

- distinguish, redefine, and clarify the legal doctrine of "ostensible agency" as it applies to medical liability (LC 5001);
- distinguish, redefine, and clarify the "captain of the ship" legal doctrine as it applies to medical liability to ensure that only the *de facto* person or entity responsible for medical malpractice is held liable *de jure* for the malpractice (LC 5004);
- prescribe the calculation of damages for a "loss of chance" as the difference between the percentage chance of recovering prior to the malpractice and the percentage chance of recovering after the malpractice, multiplied by the total damages (LC 5005);
- preclude expressions of sympathy, compassion, or benevolence from being admitted as evidence of admission of liability in a civil action for medical malpractice (LC 5007).

NOTE: As formally requested by the Legislative Council, these four bill draft requests appear on the Legislative Branch website in the LAWS database system as LCs 0460, 0461, 0462, and 0463, respectively.

⁶ It is not necessarily the case that, through their lack of support for the Subcommittee's other four recommendations, the Legislative Council concluded the four recommendations that were not supported—two tort reforms and two insurance reforms—are *not* in the interest of Montana. Rather, the conclusion should be only that there was, at the September 17 meeting, insufficient support for the proposals among the Council members.

2. The SJR 32 Subcommittee on Medical Liability Insurance

Introduction

By one means or another, the Subcommittee formed in the summer of 2003, organized itself shortly thereafter, and pursued information and answers relevant to its mission. The members reviewed numerous reports, monographs, audits, press releases, op-ed pieces, tables, charts, graphs, and the like. They solicited testimony from representatives of hospitals, nursing homes, and other health care facilities. The Subcommittee made special, concerted, and repeated efforts to obtain testimony from health care practitioners—with considerable success. The members also invited the testimony from experts in the medical liability insurance business, including a liability insurance actuary, and again had considerable success. Ample, even copious amounts of information were compiled and made available. However, separating fact from fiction, gaining a complete picture as well as an accurate picture, and determining the truly relevant issues from the spurious remained a constant challenge.

By the end of the Subcommittee's third meeting, January 15, 2004, the members had identified more than 50 ideas and options that they wanted to learn more about, discuss in more detail or discuss initially after becoming better informed, or in a few cases, perhaps, float as a trial balloon. Staff to the Subcommittee surveyed the members to determine the relative import of the issues as perceived by the members. Of the numerous options, 11 were tagged by the members as worthy of further attention by at least six of the eight members (and only one option was tagged by all eight members). Of the remaining 40 ideas, 15 were marked as worthwhile on more than half but less than three-quarters of the survey forms. The remaining two dozen

issues received a designation of deserving further attention on only half or fewer of the survey forms. (See Appendix C for the complete list and the rankings.)

A significant portion of the Subcommittee's fourth meeting was devoted to the members discussing the results of the survey and the relative merits of the ideas and options identified and ranked. The members identified 10 of the issues as meriting fuller development as draft legislation.

By early June 2004, staff had drafted and distributed the 10 bills to the Subcommittee and the known stakeholders. On June 24, the Subcommittee convened for its final meeting, the focus of which was the 10 draft bills. After a full day's effort, the Subcommittee agreed to recommend eight draft bills to the Legislative Council, i.e., the four bill drafts—LC 5001, 5004, 5005, and 5007—recommended by the Legislative Council to the 59th Legislature (as described in Chapter 1) and the four bill drafts—LC 5000, 5002, 5008, and 5009—described on the following pages.

Recommendations of the Subcommittee

The Subcommittee's recommendations, like the Legislative Council's recommendations, are presented in this report before there is any narrative or documentation that might be construed as a finding or conclusion on which the recommendation is based. The purpose of this approach, again, is to allow the reader to see "the bottom line" without having to sort through material that may or may not be of interest. As with the recommendations of the Legislative Council, however, the reader is strongly encouraged to read the entire report to gain a more complete appreciation of the information provided to and discussed by the Subcommittee.

Recommendation: Insurance Reform: LC 5000

This bill establishes the Health Care Liability and Injured Patients Compensation Act, i.e., a state-sponsored, state-mandated reinsurance program for medical malpractice liability insurance (MMLI). In short, hospitals, other health care facilities, doctors, and various other health care providers are required to participate in a reinsurance program—"the plan"—that partially indemnifies the person or entity involved in a civil action for medical negligence.⁷ Indemnification from the plan begins whenever the damages settled upon or awarded exceed \$500,000 in a single instance of medical negligence. The program is modeled on a similar program established in Wisconsin in 1975 that has reportedly been operating successfully since its inception.

As envisioned, a person or entity covered under the plan would carry primary coverage, likely purchased from a private insurer, of at least \$500,000. Any amount of liability incurred for medical negligence exceeding the \$500,000 would be a liability covered by the plan.

The plan is governed by a nine-member board of governors that administers the plan, sets premiums for the reinsurance provided by the plan, and oversees the maintenance of accounts for certain victims of medical negligence and the myriad other elements that compose an insurance plan of this nature.

Recommendation: Tort Reform: LC 5001

See discussion under Recommendations of the Legislative Council in Chapter 1.

⁷ "Medical negligence", as used in LC 5000, means a negligent act or omission of a health care provider acting within the scope of the health care provider's employment or profession while providing health care services.

Recommendation: Tort Reform: LC 5002

This bill provides that an insurer of medical malpractice liability need not pay and may not be ordered by a court to pay any type of damages, including but not limited to medical expenses and lost wages, prior to a final settlement or a judgment when liability for the act or omission and liability for the damages are reasonably clear.

LC 5002 is intended to preempt what some stakeholders view as a potential application of the reasoning stated by the Supreme Court in the *Ridley* decision.⁸ In *Ridley*, the Court, overturning the District Court, declared that an automobile liability insurer had acted in bad faith because the insurer chose not to pay for the medical expenses or lost wages of the accident victim. Medical liability insurers have become wary that the same rationale may be applied to claims of medical malpractice or negligence, even though reasonable clarity of fault is rare in contested medical liability cases.

Recommendation: Tort Reform: LC 5004

See discussion under Recommendations of the Legislative Council in Chapter 1.

Recommendation: Tort Reform: LC 5005

See discussion under Recommendations of the Legislative Council in Chapter 1.

⁸ *Ridley v. Guaranty Nat. Ins. Co.*, 286 Mont. 325, 951 P.2d 987 (1997).

Recommendation: Tort Reform: LC 5007

See discussion under Recommendations of the Legislative Council in Chapter 1.

Recommendation: Tort Reform: LC 5008

This bill statutorily prescribes the criteria by which a witness can be characterized and sworn as an "expert" in civil actions regarding medical malpractice. Statutorily prescribing criteria is considered to be necessary by some stakeholders because the Montana Legislature has not enacted a statute defining the qualifications of an "expert witness" in medical malpractice cases. Rather, the Supreme Court has ordered, by Rule, that:

if scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise.⁹

This Rule is identical to Federal and Uniform Rules (1974) Rule 702. Montana's Rule states the two common-law standards required before an expert is allowed to give his or her opinion, each of which is found in existing Montana law.¹⁰ Further, a party may through interrogatories require any other party to identify each person whom the other party expects to call as an expert witness at trial, to state the

⁹ Rule 702, Montana Rules of Evidence. The Montana Supreme Court adopts, revises, repeals, etc., the Rules of Civil Procedure. Those Rules are published in the MCA *only* as a matter of convenience and courtesy to the Judiciary and the Bar. Because the Rules are within the purview of the Judiciary—much like the Rules of the Legislature are within the purview of the Legislature—the Legislature has been "dissuaded" from attempting to revise, adopting, or repealing the Supreme Court's Rules.

¹⁰ See "Commission Comments" under Rule 702, Montana Rules of Evidence, under Title 26, ch. 10, part VII, MCA annotations.

subject matter on which the expert is expected to testify, and to state the substance of the facts and opinions to which the expert is expected to testify and a summary of the grounds for each opinion. (See Rule 26(b), Montana Rules of Civil Procedure, under Title 25, chapter 20, MCA.) As written, LC 5008 prescribes for the judge and the court criteria for witnesses seeking expert status in medical malpractice cases only. The qualifications of expert witnesses in all other matters of liability stand to be assessed under Rule 26(b).

Recommendation: Insurance Reform: LC 5009

This bill establishes, under statutorily prescribed conditions, a joint underwriting association consisting of all insurers authorized to write and engaged in writing medical malpractice insurance in Montana. (Comparable statutes were enacted in the late 1970s, in response to the first MMLI crisis.) The purpose of the association is to provide primary medical malpractice insurance to certain health care providers on a self-supporting basis. Each insurer must remain a member of the association as a condition of the insurer's authority to continue to write medical malpractice insurance in Montana. Unlike the reinsurance provided under LC 5000, the joint underwriting association created in LC 5009 is a primary insurer. Finally, the conditions under which the association may or must operate is whenever the insurance commissioner determines that medical liability insurance is not available for certain health care providers in the voluntary market. As MMLI again becomes available in the voluntary market, the association must discontinue its underwriting operations.

Reviewing information provided in Chapters 3 and 4 and the appendices that was available to the Subcommittee may provide insight into the Subcommittee's decisions.

Recapitulation of the Subcommittee's Recommendations

The Subcommittee concluded that establishing a medical liability reinsurance program could help to alleviate increasing prices and decreasing availability of medical liability insurance. In response, the Subcommittee recommends LC 5000, a bill establishing the Health Care Liability and Injured Patients Compensation Act.

The Subcommittee also determined that revising various tort laws was in the interest of Montana. Consequently, the Subcommittee recommended to the Legislative Council LCs 5001, 5002, 5004, 5005, 5007, and 5008.

Respectively, the six bills revise or establish statutes that:

- distinguish, redefine, and clarify the legal doctrine of "ostensible agency" as it applies to medical liability;
- limit any requirement to pay medical expenses and lost wages for medical malpractice prior to a final settlement or a judgment whether or not liability for the malpractice and the damages are reasonably clear;
- distinguish, redefine, and clarify the "captain of the ship" legal doctrine as it applies to medical liability to ensure that only the *de facto* person or entity responsible for medical malpractice is held liable *de jure* for the malpractice;
- prescribes the calculation of damages for a "loss of chance" as the difference between the percentage chance of recovering prior to the malpractice and the percentage chance of recovering after the malpractice, multiplied by the total damages;
- preclude expressions of sympathy, compassion, or benevolence from being admitted as evidence of admission of liability in a civil action for medical malpractice; and
- forge objective, statutory criteria by which a witness can be characterized and sworn as an "expert" in civil actions regarding medical malpractice.

Finally, the Subcommittee determined that the state should create a "safety valve" for certain medical care providers who cannot obtain affordable MMLI. Accordingly, the Subcommittee recommended reauthorizing a joint underwriting association consisting of all insurers sanctioned to write and engaged in writing medical malpractice insurance in Montana.¹¹ This recommendation is detailed in LC 5009.

¹¹ At the September 17, 2004, meeting of the Legislative Council, this category of insurers was clarified and expanded to all insurers sanctioned to write and engaged in writing casualty/liability insurance in Montana.

3. Assessing the Medical Liability Terrain

As characterized in SJR 32, the study issues were relatively straightforward: recent experience with and alarm from increasing rates for medical malpractice liability insurance (MMLI); and public policy options potentially available to address the problems identified. Indeed, testimony provided at hearings on SJR 32 noted that some health care facilities had experienced MMLI premium increases on the order of 1,000% or more over the past 2 or 3 years.¹² Montana was not alone, however, as other states reportedly were experiencing similar circumstances regarding MMLI.¹³

In addition to rising MMLI premiums, medical facilities and medical practitioners had also sounded the alarm that MMLI was becoming increasingly difficult to obtain, at any price, because insurers were leaving the MMLI market. For example, the American College of Physicians pointed out:

The St. Paul Companies of Minnesota (the nation's second largest medical insurance underwriter), PHICO, Frontier, and Reliance have announced [in 2001] that they would no longer write professional medical liability policies, leaving policies for well over 50,000 physicians and hospitals to expire.¹⁴

¹² *Minutes*, Senate Judiciary Committee, April 11, 2003, testimony of Senator Duane Grimes.

¹³ See, e.g., *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, U.S. General Accounting Office, June 2003 (GAO-03-702); "Medical Malpractice Reform High On States' Agenda", by Erin Madigan, at Stateline.org; URL www.stateline.org/stateline/?pa=story8sa=showStoryInfo&id=317849, July 29, 2003; "Priority Issue—Professional Liability Insurance Reform", American Osteopathic Association, URL <http://www.aoa-net.org/Government/stateaffairs/stategov.htm>.

¹⁴ "Professional Liability Reform", American College of Physicians, available online at URL http://www.acponline.org/hpp/liability_ref.htm.

Nature and scope of the Montana medical liability insurance crisis

SJR 32, in the "whereas" clauses, laid out the basic premises for the resolution and study. In the first clause it states "many health care providers in Montana are alarmed at the rising cost of liability insurance". In the third clause it states that the number of MMLI insurers "has declined significantly in the past few years". The first statement refers to a price component of the crisis while the second statement refers to an availability component. Each of the components was testable because some MMLI price and availability data was available. Beyond the price and availability components, there is a third component, at least, which is identified in subsections (2) and (4) of the first "resolved" clause: policy options that may be available to Montana's Legislature to address causal factors of the MMLI crisis. Inherent in the third component is a review of steps that Montana had previously undertaken to address similar crises in the past.¹⁵

A broader view

Presenting a multistate viewpoint, the Council of State Governments (CSG) had recently published (April 2003) a report that characterized the crisis somewhat differently from SJR 32. As CSG reported it:

Medical malpractice is a three-pronged problem. First, there are the medical care providers whose mistakes lead to medical malpractice claims. Second, the legal system requires a great deal of time, effort and money to determine fault, so it's an inefficient means of settling malpractice claims. Third, the medical malpractice insurance industry

¹⁵ The SJR 32 Subcommittee on Medical Liability Insurance began to examine policy options at its meeting of November 15, 2003. The 54th Legislature (1995) adopted an array of "tort reforms" that resulted, in part, from a study conducted during the 1993-94 interim. See *Medical Malpractice and Tort Reform: Issues of Insurance Costs, Coverage, Caps, and Compensation*, Montana Legislative Council, November 1994.

raises and lowers premiums, not based on a physician's track record, but partly on the ups and downs of the national economy.¹⁶

Certain information regarding medical practice, the legal environment, and the MMLI industry was examined independently and interdependently. Some of the information was readily available, but only some.¹⁷ Therefore, the Subcommittee (and ultimately the Legislative Council) found it difficult to reach consensus on some issues, factors, findings, and, in particular, consensus conclusions that could be vigorously supported with data and empirical evidence.

Laying a foundation

Proposing a solution before identifying the problem to be solved is generally not a good idea. A rational place to begin the study of MMLI was to establish whatever factual information could be established. However, it is doubtful that "facts" alone were sufficient for the Subcommittee to reach meaningful findings and conclusions and the same holds for the Legislative Council. As evidence, a legislative staffer from California, a state that has a long history of public policy interaction with medical malpractice issues, characterized his experience and observation quaintly:

... the med mal issue is characterized by absolutely contradictory information by both sides, and sorting out the reality and fact is difficult.

John Miller, Staff, California Senate Office of Research

¹⁶ *Medical Malpractice Crisis*, Council of State Governments, Lexington, KY, April 2003 (revised May 2003), p.1.

¹⁷ *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, U.S. General Accounting Office, June 2003, pp. 22, 45 (GAO-03-702); *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, U.S. General Accounting Office, August 2003, p. 17-21. (GAO-03-836)

The literature seemed to support Miller's contention.¹⁸ Consequently, the reported facts first had to be understood within the context of their origins, i.e., the age-old who, what, when, where, why, and how. Second, policymakers and others had to determine how those facts may relate to public policy options for Montana.

The insurance component of the crisis

A cost crisis

It was and remains difficult to establish the breadth and depth of the MMLI cost crisis in Montana. Understandably, it would be alarming for a hospital administrator to see the MMLI premium for his or her facility increase from \$9,000 in one year to \$90,000 only two years later or from \$8,000 to \$66,000 in a similar timeframe.¹⁹ What these two examples don't disclose, unfortunately, are any other factors that may have affected the changes in premiums.

Aggregated data for Montana showed that the total net premiums for MMLI in Montana rose from about \$16.95 million in 1998 to \$22.89 million in 2002.²⁰ More current information shows net premiums for 2003 at \$26.74

¹⁸ See, e.g., "Beyond MICRA: New Ideas for Liability Reform", American College of Physicians, online at URL <http://www.acponline.org/hpp/pospaper/micra.htm/htm>, undated; "The Impact of Medical Malpractice Insurance and Tort Law on Washington's Health Delivery System", Washington State Medical-Education and Research Foundation, September 2002; "Confronting the Myths on Medical Liability Reform", American Medical Association, position paper, undated; "MICRA vs. Prop. 103", American Medical Association, position paper, undated; *The Medical Malpractice Insurance Crisis: Opportunity for State Action*, by Mimi Marchev, National Academy for State Health Policy, July 2002; *Premium Deceit: The Failure of "Tort Reform" to Cut Insurance Prices* by J. Robert Hunter and Joanne Doroshow, Center for Justice and Democracy, Washington, DC, 2002.

¹⁹ Testimony of John Flink, Montana Hospital Association, *Minutes*, Senate Judiciary Committee, April 11, 2003.

²⁰ From "Detail Business in the State" (series 1998-2002), State Insurance Commissioner, Helena, MT.

million.²¹ At \$9.8 million or 58% (nominal) over the 6-year period, the increase is notable. Even after run-of-the-mill inflation is factored in at approximately 2.5% annually over the 6-year period, the "real" or "inflation-adjusted" change in net premiums would be about \$7.55 million or 45% over the period. Stated differently, the annual increase in total MMLI net premiums in inflation-adjusted terms from 1998 through 2003 would be about 9.5% per year.²²

An availability crisis

With respect to the MMLI availability component, the announcement in December 2001²³ of the St. Paul Companies' departure from the MMLI marketplace had been cited as a significant MMLI development, markedly significant in some states and relatively significant nationwide.²⁴ Through 2002, however, St. Paul's departure from the market did not appear to have been that significant for Montana as a whole—at least not at that time.

In 1998, for example, the St. Paul Companies accounted for about 12.5% of MMLI net premiums reported in Montana.²⁵ By 2002, the St. Paul Companies

²¹ "2003 Detail Business in the State", State Insurance Commissioner, Helena, MT.

²² The 9.5% annual inflation in premiums is nearly 50% higher than long-term (>25 years) medical inflation of approximately 6.7%. (Staff estimate from Exhibit 3 in *Medical Malpractice Insurance: Stable Losses/Unstable Rates 2003*, Americans for Insurance Reform, November 2003, p. 7.) See also, "Commentary: A Second Opinion on the Malpractice Plague", by Lorraine Woellert, *BusinessWeek* online, March 3, 2003, in which the *Journal of Health Affairs* is cited as the source of medical inflation of 6.7% from 1990 to 2001.

²³ "The St. Paul Companies, Inc. Exits Certain Businesses", (December 12, 2001) in Key Developments at MSN Moneycentral, <http://news.moneycentral.msn.com/ticker/sigdev.asp?Symbol=sta>)

²⁴ See *The Medical Malpractice Insurance Crisis: Opportunity for State Action*, by Mimi Marchev, National Academy for State Health Policy, July 2002, p. 6 (esp. footnote no. 14).

²⁵ "1998 Detail Business in the State: Medical Malpractice", State Insurance Commissioner, Helena, MT.

share had declined to about 8.3% of MMLI net premiums,²⁶ then to about 2.7% of net premium in 2003.²⁷

From a statewide perspective of MMLI availability, available data showed that there were 56 insurers offering MMLI in Montana in 1998, with 40 of them actually reporting net premiums. By 2002, the number of insurers offering MMLI had actually increased to 57, with 38 of them reporting net premiums from MMLI, and by 2003, 60 insurers offered MMLI and 39 reported net premiums. Over the 6-year period, the number of MMLI insurers licensed and reporting net premiums in Montana remained essentially constant.²⁸ These figures directly contradict language in SJR 32, specifically the statement that "the number of insurance carriers that provide liability insurance for hospitals, clinics, and nursing homes has declined significantly in the past few years".

The severity of the crisis in Montana

One factor that called into question the severity of the MMLI crisis in Montana was a then-recent report (August 2003) from the U.S. General Accounting Office. As stated in the audit report:

In the absence of reliable national sources of data concerning provider responses to rising malpractice premiums, we focused our review on nine states selected to encompass a range of malpractice premium pricing and tort reform environments. Five of these states [FL, MS, NE, PA, WV] were among those cited by AMA and other national health care provider organizations as malpractice "crisis" or "problem" states based on such factors as higher than average increases in malpractice insurance premium rates, physicians' reported difficulties obtaining

²⁶ "2002 Detail Business in the State: Medical Malpractice", State Insurance Commissioner, Helena, MT.

²⁷ "2003 Detail Business in the State: Medical Malpractice", State Insurance Commissioner, Helena, MT.

²⁸ "Detail Business in the State" (1998-2002 series) , State Insurance Commissioner, Helena, MT.

malpractice insurance coverage, and reports of actions taken by providers in response to the malpractice-related pressures of rising premiums and litigation. The remaining four states [CA, CO, MN, MT] were not cited by provider groups as experiencing malpractice-related problems.²⁹ (*Emphasis added.*)

Assuming that the GAO auditors correctly compiled and accurately reported their findings, at least the Montana Medical Association and some other Montana health care providers did not view Montana as a state contending with an MMLI crisis.³⁰

Factors contributing to increased premium rates

To the extent MMLI premium rates and availability are resulting in a crisis across Montana or only in scattered localities or within certain medical specialties only, there are certain factors that may be causing the circumstances. For example, the U.S. General Accounting Office noted four separate categories of factors that contribute to changes in premium rates.

Insurers' losses, declines in investment income, a less competitive climate, and climbing reinsurance rates have all contributed to rising premium rates. First, among our seven sample states, insurers' losses have increased rapidly in some states, increasing the amount that insurers expect to pay out on future claims. Second, on the national level insurers' investment income has decreased, so that insurance companies must increasingly rely on premiums to cover costs. Third, some large medical malpractice insurers have left the market in some states because selling policies was no longer profitable, reducing the downward competitive pressure on premium rates that existed through

²⁹ *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, U.S. General Accounting Office, August 2003, p. 3. (GAO-03-836). The five states with reported (MMLI) problems are Florida, Mississippi, Nevada, Pennsylvania, and West Virginia. The four states without reported (MMLI) problems are California, Colorado, Minnesota, and Montana.

³⁰ The "other entity" providing information on the cost/availability components in Montana was the Association of Montana Health Care Providers. (See *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, U.S. General Accounting Office, August 2003, App. I, p. 42. (GAO-03-836).)

most of the 1990s. Last, reinsurance rates for some medical malpractice insurers in our seven sample states have increased substantially, increasing insurers' overall costs. In combination, all the factors affecting premium rates and the availability of medical malpractice insurance contribute to the medical malpractice insurance cycle of hard and soft markets.³¹

Insurers' losses are, in a nutshell, the amount of net premium, investment, and other income taken in by an insurer minus the amount of claims paid out by the insurer over the same time period. Several studies have found that these losses are the primary contributor to higher MMLI premiums.³²

There are many variables that must be accounted for within the loss equation. To complicate matters, the ways in which changes in premiums, investment and other income, and claims paid and claims incurred interact vary among insurers, jurisdictions (both individual states and within any given state), different medical practices or specialities, different medical facilities, etc. Additionally, the numerous variables can be directly or indirectly affected by various economic, demographic, scientific, technological, cultural, legal, and other influences.

The second factor cited, declines in investment income, depends on numerous subfactors, including the type of insurer, the amount of investable principle, rates of return, duration of investment of principle, etc. For example:

- a "mutual insurance company" may not have access to the same types of investable capital that a publicly traded insurance company has access to;

³¹ See *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, U.S. General Accounting Office, June 2003, p. 15 (GAO-03-702).

³² Ibid.

- when an insurer has large amounts of investable capital, it has investment options, e.g., certain privately placed bonds, convertible bonds, etc., that realistically are not options for insurers with less investable capital;
- a riskier investment typically carries a higher rate of return, but a company with a weak balance sheet cannot prudently accept the higher risk even when the anticipated return is also higher. An insurer with a strong balance sheet may be able to prudently invest in some higher-risk instruments without jeopardizing its solvency.
- longer-term fixed investments, including bonds, money markets, etc., typically have higher returns than comparable shorter-term fixed investments. An insurer with a strong balance sheet may prudently invest in longer-term, higher-return fixed instruments without unduly affecting viability; an insurer with a weaker balance sheet may not have the same luxury.
- when the stock market is healthy, the bond market is not. Perhaps counter intuitively, a weak bond market means that rates of return on debt instruments are higher than when the bond market is strong. Insurers rely primarily on debt instruments³³, such as bonds, as investments and those types of investments generated relatively high returns during the 1990s. As the stock market bubble burst in early 2000, the bond market began to rally and fixed-investment returns to insurers began to decline.

Unquestionably, there are other factors that can affect investment income. Understanding each of the (major) factors and how each of the factors interact, both for the MMLI industry as a whole and for individual insurers, is necessary to understand how the investment income factor can affect MMLI premiums.

The third factor, a less competitive climate, is a result of other factors as well, including a reduction in the numbers of available MMLI insurers. With less competition, it is easier for any of the remaining insurers to increase

³³ Ibid., p. 4.

premium rates. Fewer providers in the MMLI market can occur for various reasons, including nonprofitability of the departed insurer's MMLI insurance line, an insurer's insolvency (bankruptcy), industry consolidation (mergers and acquisitions), etc. However, available data for Montana (2003) does not support the contention that there are fewer insurers in Montana.³⁴ In fact, the data shows that the number of medical liability insurers has remained virtually constant for the past 5 or 6 years.

Finally, the cost and availability of reinsurance also affects the pricing of MMLI. Reinsurance is insurance for insurers. Insurers purchase reinsurance to spread the risk of claims or losses in excess of those initially anticipated by the insurer.³⁵ Whenever an "input" cost, such as reinsurance, of the MMLI premium increases, the MMLI premium must also increase if the profitability of the insurer or at least an insurance line is to be maintained.

The medical system component of the crisis

Without real and alleged malpractice by medical practitioners and medical facilities, there would be no need for MMLI and, hence, there would be no MMLI crisis. But medical errors do occur and those errors are sometimes the result of malpractice. As reported by the organization Public Citizen:

According to the Institute of Medicine (IOM), which completed a comprehensive report on the medical malpractice issue in 1999, medical errors "are a leading cause of death in the United States.... At least 44,000 and perhaps as many as 98,000 Americans die in hospitals each year as a result of medical errors. Deaths due

³⁴ "Detail Business in the State" (1998-2003 series) , State Insurance Commissioner, Helena, MT.

³⁵ Many insurers purchase reinsurance and some also sell reinsurance. Thus, the effects of major casualties, e.g., Hurricane Andrew in 1992 or the events of September 11, 2001, can have considerable impact on the overall profitability of a given insurer. For example, the St. Paul Companies were reinsurers affected by 9/11/01.

topreventable adverse events exceed the deaths attributable to motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).³⁶

The medical community, insurance companies, injured parties, and others would prefer that malpractice did not occur at all. Because it does, however, the ways in which the medical community is "regulated" or "policed" may have implications for MMLI rates and availability and for public policy options.

The legal system component of the crisis

If doctors, hospitals, insurers, attorneys, and other stakeholders in the MMLI crisis can agree on anything, it would probably be that truly injured parties deserve just compensation for the injury. But the devil is in the details and whatever agreement might exist initially often ends quite abruptly.

Disbelief is probably as good a description as any of the initial reaction many people have when they hear of a case in which the injured party reportedly receives an award that is seemingly exorbitant given the reported extent of the injury. A second reaction may be disillusionment with a legal system or process that concludes with a seemingly irrational result, for example, the often-reported McDonald's coffee case.³⁷

³⁶ *Florida's Real Medical Malpractice Problem: Bad Doctors and Insurance Companies Not the Legal System*, Public Citizen, Washington, D.C., 2001, p. 3. (Originally from Institute of Medicine, *To Err is Human: Building a Safer Health System*, Washington D.C., National Academy Press, 1999, p. 26.)

³⁷ "The 'McDonald's Coffee Case' and Other Fictions", Center for Justice and Democracy, NY, NY, undated. This case involved a woman who had spilled a cup of McDonald's coffee in her lap. It was initially and repeatedly reported that she had been awarded \$3 million for the mishap, i.e., \$200,000 in compensatory (actual) damages and \$2.7 million in punitive damages. Penultimately, the judge reduced the award to approximately \$640,000, i.e., \$160,000 actual and \$480,000 punitive. Subsequently, the parties entered a post-verdict settlement.

As frequently derided as it is whenever associated with medical malpractice liability, the legal system comes into the picture only if an injured party believes that his or her injury is the result of malpractice and, subsequently, that adequate compensation for the injury is not forthcoming without resorting to legal means. Instances of malpractice for which claims are made are in the significant minority, however. Specifically with respect to injury as a result of medical malpractice, estimates of the number of claims filed range from about 1 claim for every 6 injuries³⁸ to 1 claim for every 8 injuries.³⁹ Additionally, estimates of the likelihood that a claim results in compensation to the plaintiff range from about 1 in 2 to 1 in 4 of the claims filed.⁴⁰

Differences of experience and opinion

In addition to the issue of the frequency of claims made for medical malpractice is the related issue of the severity of claims. In a 2002 study commissioned by the U.S. Department of Health and Human Services, the need for tort reform at the national level was seen as crucial.

... Increasingly, Americans are at risk of not being able to find a doctor when they most need one because the doctor has given up practice, limited the practice to patients without health conditions that would increase the litigation risk, or moved to a state with a fairer legal system where insurance can be obtained at a lower price.

This broken system of litigation is also raising the cost of health care that all Americans pay, through out-of-pocket payments, insurance premiums, and federal taxes. Excessive litigation is impeding efforts to improve quality of care. Hospitals, doctors, and nurses are reluctant to

³⁸ *Florida's Real Medical Malpractice Problem: Bad Doctors and Insurance Companies Not the Legal System*, Public Citizen, Washington, D.C., 2001, p. 4.

³⁹ *Medical Malpractice: Perceptions and Misperceptions*, American Bar Association, Feb. 1995, p. 8. One report on MMLI suggests that the likelihood of compensation being paid to an injured party may be as remote as 3%, i.e., only 3 of 100 injured parties actually receive compensation. (*Medical Malpractice Crisis*, Council of State Governments, April 2003, p. 9.)

⁴⁰ See, e.g., *The Medical Malpractice Insurance Crisis: Opportunity for State Action*, by Mimi Marchev, National Academy for State Health Policy, July 2002, p. 3.

report problems and participate in joint efforts to improve care because they fear being dragged into lawsuits, even if they did nothing wrong.

Increasingly extreme judgments in a small proportion of cases and the settlements they influence are driving this litigation crisis. At the same time, most injured patients receive no compensation.⁴¹

Similar to other aspects of the crisis, there is fundamental disagreement about historical and recent changes in the severity of claims. For example, the U.S. General Accounting Office states:

... the average reported claims payment made on behalf of physicians and other licensed health care practitioners in 2001 was about \$300,000 for all settlements, and about \$500,000 for trial verdicts.⁴²

BusinessWeek online, an affiliate of *Business Week* magazine, gives a second opinion on the tort reforms being discussed at the national level:

... The size of damage claims paid out by physician insurers has been more or less steady since 1991, according to the National Practitioner Data Bank, a government service that tracks doctor errors and malpractice claims. The mean payout was \$135,941 in 2001, up 8.7% from \$125,000 a year earlier. Over 10 years, malpractice payouts have grown an average of 6.2% a year.

Guess what? That's almost exactly the rate of medical inflation: an average of 6.7% between 1990 and 2001, according to the Journal of Health Affairs. It's also worth noting that, nationwide, malpractice payouts by physicians and their insurers were a mere \$4.5 billion in 2001—less than 1% of the country's overall health-care costs of \$1.4 trillion. They have risen slowly, if steadily, since 1996, when the total was \$3.5 billion.⁴³

⁴¹ *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System*, U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, July 24, 2002, p. 1. Online at URL <http://aspe.hhs.gov/daltcp/reports/litrefm.pdf>

⁴² *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, U.S. General Accounting Office, August 2003, p. 8. (GAO-03-836).

⁴³ "Commentary: A Second Opinion on the Malpractice Plague", by Lorraine Woellert, *BusinessWeek online*, March 3, 2003.

The American Osteopathic Association asserts:

[A] report by Jury Verdict Research has shown that jury awards and verdicts doubled from 1995 to 2000. The median award in 1995 was \$500,000. Six years later in 2001 (the latest figure available), the median award was \$1 million, after increasing by more than 40 percent in 2000.⁴⁴

On the same topic, Weiss Ratings, Inc.⁴⁵, offers its opinion:

The median payout in states without caps surged 127.9 percent, from \$65,831 in 1991 to \$150,000 in 2002. In contrast, the median payout grew by 83.3 percent in states with caps, from \$60,000 to \$110,000. Likewise, in states without caps, the median payout for the entire 12-year period was \$116,297, ranging from \$75,000 to \$220,000, while the median payout for states with caps was 15.7 percent lower, or \$98,079, ranging from \$50,000 to \$190,000.⁴⁶

And, finally, from Americans for Insurance Reform:

New insurance industry data and analysis...shows that the average medical malpractice insurance payout, or closed claim, has been only \$28,524 over the last decade. Payouts in 2001 follow the same low pattern. This figure includes all jury verdicts, settlements and other costs used by insurers to fight claims in court. Moreover, medical malpractice insurers are paying nothing in 77 percent of all claims filed; in the 23 percent of cases where insurers pay anything, the average claim is only \$107,587. According to the Harvard Medical Practice

⁴⁴ *Priority Issue: Professional Liability Insurance Reform*, AOAnet, no author or date. On the internet at URL <http://www.aoa-net.org/Government/stateaffairs/stategov.htm>.

⁴⁵ Weiss Ratings, Inc., according to its website, evaluates "the financial stability of over 16,000 financial institutions, including banks, insurance companies, HMOs, and securities brokers. Weiss also rates the risk-adjusted performance of over 12,000 mutual funds including stock funds, bond funds, and money market funds, and over 9,000 common stocks." Source: http://www.libraryresource.com/entries/weiss_ratings_inc.,insurance.shtml

⁴⁶ "Medical Malpractice Caps Fail to Prevent Premium Increases", Weiss Ratings, Inc., June 3, 2003, online at URL http://weissratings.com/News/Ins_General/20030602pc.htm. NOTE: Montana has had the AMA-recommended cap on noneconomic damages, \$250,000, since 1995.

Study, only one in eight malpractice victims ever files a claim for compensation.⁴⁷

Searching for causal factors

Identifying the specific cause or causes of rising premiums is, at best, elusive. On the one hand, representatives of medical facilities and medical providers and various insurers have identified the costs of tort actions, both those that are settled and those that are litigated, as a primary driver in spiraling MMLI costs.⁴⁸ In one release, the American Medical Association leaves few questions about its position:

Today's report also puts to rest two other trial lawyer smokescreens: that insurance company gouging and/or stock market losses have caused the medical liability crisis. Today's report makes clear that bonds make up 80 percent of insurers' investments and that 'no medical malpractice insurers experienced a net loss on their investment portfolios.' The GAO report also states that insurer 'profits are not increasing, indicating that insurers are not charging and profiting from excessively high premium rates.' It also notes that insurance regulators in most states have the authority to deny excessive premium rates.⁴⁹

The American Tort Reform Association, a compatriot of the AMA, apparently holds similar views:

⁴⁷ "New Study Shows Average Medical Malpractice Payout over Last Decade Only \$28,524; New Data Reveals Same Trends in 2001", Americans for Insurance Reform, January 23, 2003, online at URL <http://www.centerjd.org/air/pr/release030123.html>.

⁴⁸ "Warning to Senate Judiciary Committee to Curb Medical Liability Excesses", American College of Physicians, online at URL http://www.acponline.org/hpp/liability_excess.htm.

⁴⁹ "Increasing lawsuit awards are the main cause of skyrocketing liability insurance rates", attributed to Donald J. Palmisano, MD, AMA President, July 28, 2003. URL www.ama-assn.org/ama/pub/article/1617-7913.html. The "report" referred to in the statement is a report prepared by the U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, U.S. General Accounting Office, June 2003 (GAO-03-702).

The fact is that medical malpractice insurance premiums have skyrocketed because both the frequency and severity of claims are on the rise.⁵⁰

And the American Academy of Dermatology Association echoes the sentiment:

The root cause of this problem [*rising premiums*] is the unrestrained escalation of jury awards and settlements. These awards and settlements are driving up liability insurance premiums for physicians, including dermatologists, and are forcing insurance companies out of the business of providing medical liability insurance.⁵¹

On the other hand, the contingent of the Bar often referred to as trial lawyers has a distinctly different perception of the causes of rising rates, particularly as malpractice awards or malpractice litigation in general are characterized as direct "causes" of the MMLI crisis.

Investment income is down, and as a result, the insurance industry is now charging higher medical malpractice premiums. The American Medical Association (AMA) is calling for federal legislation that preempts state medical professional liability laws to limit compensation to patients injured by malpractice because the AMA assumes such limits will reduce malpractice rates. However, there is no evidence that limiting compensation to injured patients will have a real impact on malpractice rates. The AMA is carrying on a multi-million dollar public relations campaign to gain public support for such federal legislation and for tort law changes at the state level.

... The ABA urges the legal and medical professions to cooperate in seeking a solution to medical liability problems and maintains that federal involvement in the area is inappropriate. In particular, the ABA opposes caps on pain and suffering awards, supports retaining current tort rules on malicious prosecution, collateral sources and contingent fees, and believes that the use

⁵⁰ "John Edwards Botches the Facts on Medical Liability", American Tort Reform Association, May 23, 2003, online at URL <http://www.atra.org/show/7568>.

⁵¹ "Medical Liability Reform Talking Points", American Academy of Dermatology Association, Gov't Affairs, 2003, online at URL http://www.aadassociation.org/Medical_Liability_Reform_TP.html

of structured settlements should be encouraged. It also supports certain changes at the state level in the areas of punitive damages, jury verdicts and joint and several liability.⁵²

The ABA's perception is apparently shared by researchers at the Center for Justice and Democracy:

... [research] indicates that there is a modest rise in insurance rates/loss costs from the adoption of mid-range tort reforms for the Medical Malpractice category. That is, the underlying costs, which ultimately drive insurance prices, are impacted *upwardly* by mid-range medical malpractice tort law changes of the type adopted in this nation since the liability insurance crisis of the mid-1980s. This is counter-intuitive. While there does appear to be a reduction in rates/loss costs from severe tort law changes in medical malpractice... the mixed results confuse any conclusion. One reasonable conclusion is that no clear evidence of tort law change impacting insurance prices is determinable from these data.... Indeed, there is no evidence that general, across-the-board "tort reform" (or product liability "tort reforms") has lowered insurance rates/loss costs.⁵³ (Emphasis in original.)

As if the disagreement between the tort reformers and the insurance reformers wasn't sufficiently confusing, testimony to and information distributed to the Subcommittee by the Montana Medical Legal Panel staff provided some downright confounding information and insights. In his testimony to the Subcommittee,⁵⁴ Gerald Neely, Esq., referred to his findings from a Fall 2003 survey of the membership of the Montana Medical Association and labeled some of his findings as "new and startling information", including:

⁵² "Tort Law: Medical Professional Liability", 2003 Legislative Priorities, American Bar Association, July 23, 2003, online at URL <http://www.abanet.org/poladv/priorities/impl.html>.

⁵³ *Premium Deceit: The Failure of "Tort Reform" to Cut Insurance Prices* by J. Robert Hunter and Joanne Doroshow, Center for Justice and Democracy, NY, NY, 2002, pp. 17-18.

⁵⁴ The statements attributed to Gerald Neely are taken from the *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, Nov. 17, 2004, pp. 13-16. The author exercised editorial license to make a few of Mr. Neely's statements more readable, without changing the statements' substance.

- The new information revealed that the bulk of the physicians and hospitals, in essence, "own" their own insurance carriers. He said he didn't have exact percentages but he estimated more than 70% of Montana physicians are insured by their own carriers. This creates, in his opinion, a contradiction in the medical malpractice liability insurance issue and a question of why there has been no discussion on these self-insured programs.

- The focus and concern must be on these carriers who represent the bulk of the hospitals and physicians, and where they are in the percentages.

- Another crucial factor is the notion held by some that there has been a significant increase in the claims made in Montana. This has been totally contrasted by the testimony, witness after witness, that physicians and facilities have not experienced a rise in the number of claims. Mr. Neely stated, "The fact of the matter is that Montana has an absolute recent decline in the number of claims per physician." There is one source of data for this information, which is the Montana Medical Legal Panel. Mr. Neely said, to his knowledge, there was no contrary authority published anywhere in the United States that indicates that the rate of claims in Montana has increased. The National Practitioner Data Bank... doesn't collect information on the rate of claims, only information on the rate of paid claims.

- Per 1,000 physicians, in an absolute sense, the rate of claims and the rate of cases filed are both diminishing in Montana. In 2000, Montana had a total of 93 paid claims, as reported by the National Practitioner Data Bank. In 2001, Montana had 67 paid claims and in 2002, Montana had 69 paid claims. Mr. Neely said if the number of claims paid in Montana is divided by the number of people in Montana, and if that number is compared with the same number from other states, the rate of paid claims in Montana is high but not in absolute numbers; only in dollars paid out on those claims.

- In Montana, there is a lower number of absolute claims, a lower rate of claims and rate of paid claims, and there have only been three claims paid out in excess of \$1 million from 1995 through the current year [2003 November].⁵⁵

- According to the data of the Utah Medical Insurance Association and the data from The Doctors Company, a large loss problem is not indicated. Mr. Neely said he knew for a fact that, according to the UMIA rate card, premium rates were only increased 25% last year and that The Doctors Company had actually reduced premiums in some specialties. He said he found it puzzling that doctors had reported such huge increases in insurance premiums, in light

⁵⁵ The statement regarding "3 claims in excess of \$1 million" was presumably accurate when it was made in Nov. 2003. However, it is now reported that there have been 4 such claims paid. See *Year 2004 Montana Medical Legal Panel Report*, G. Brian Zins, Montana Medical Legal Panel, Feb. 27, 2004, p. 8.

of this information, and said the testimony heard last night and today did not "square" with the insurance company information.

- Data indicates that 25% of Montana doctors have coverage in excess of \$2 - \$4 million and 30% have \$1 - \$3 million. The doctors are overpaying because the claims history doesn't support the need for this level of coverage.

Perhaps not surprisingly, Dr. Kurt T. Kubicka, on behalf of the Montana Medical Association, took issue with Mr. Neely's findings and testimony from November 2003. In a letter to the Subcommittee, Dr. Kubicka noted broad-based premium rate increases of 25% in each of 2003 and 2004, one major medical liability insurer who anticipates incurring losses of "\$1.38 for every dollar of premium received", and current conditions that are "worsening and accelerating".⁵⁶

⁵⁶ See letter to SJR 32 Subcommittee on Medical Liability Insurance, January 13, 2004, from Kurt T. Kubicka, M.D., President, Montana Medical Association, in *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, Jan. 15, 2004, as Exhibit #15.

4. Examining Montana's and Other States' Medical Liability Laws

State policymakers have various options that may or may not affect MMLI premiums. For Montana policymakers, some of those options were visited in previous MMLI crises in the 1970s and 1980s and, most recently, revisited in the 1993-94 interim. In 1995, the 54th Legislature enacted some of the options⁵⁷ that, today, are being strenuously advocated and, simultaneously, strenuously resisted at the national level. In the spirit of the SJR 32 direction to review measures adopted by other states to address the liability insurance problems, the Subcommittee was presented with then-recent action in Florida that had included examining MMLI options considered by other states. In Florida, the Governor's Select Task Force on Healthcare Professional Liability Insurance ultimately made 60 recommendations distributed across five categories.⁵⁸

Using the Florida categories as a broad outline, numerous elements remained within the category of establishing a factual foundation of MMLI in Montana and the Subcommittee considered examining the same or similar broad categories.

Health care quality. Had this category become a focus, various statistical and other information would have been compiled and analyzed regarding the nature and scope of medical malpractice in Montana. Included in this category might be an examination of the law and practice regarding the reporting of medical errors, both committed and observed; various patient

⁵⁷ See House Bill No. 309, Ch. 461, Laws of Montana 1995.

⁵⁸ *Governor's Select Task Force on Healthcare Professional Liability Insurance*, final report, pp. vii - xvi.

safety initiatives; health care or patient safety "demonstration projects"; reviewing statutory or other requirements for patient safety in medical facilities; within the insurance code, potential changes intended to reduce MMLI premiums; and educating the public on health care. This category of information was not pursued by the Subcommittee.

Physician discipline. Examining this category would have involved compiling and reviewing statistical and other information on the extent to which medical errors are committed, observed, and reported and that might be preventable. Subcategories might have included quasi-judicial review initiatives; clarifying the scope of regulatory or licensing authorities regarding standards of care; the establishment or codification of standards of care; periodic independent review of physician discipline; the confidentiality of certain, particularly sealed, records regarding medical error; physician profiles; mediation initiatives; burden of proof requirements in disciplinary proceedings; and use of the Internet to promote and ensure systemic integrity. This category of information was not pursued by the Subcommittee.

The need for tort reform. Topics falling under this category included measuring the effects of existing "tort reforms" enacted previously in Montana or elsewhere; visiting or revisiting the efficacy of previously adopted or considered reforms; various aspects of civil procedures regarding medical malpractice claims; qualifications of expert witnesses; liability for emergency services; sovereign immunity from medical malpractice under certain circumstances; payment of damages; prelawsuit initiatives; and plaintiff attorney fees.

Considerable material and testimony relevant to this category was provided by various stakeholders, which may have influenced the Subcommittee's requests of staff to compile and provide additional information relevant to

"tort reforms". In fact, much of the Subcommittee attention was devoted to identifying additional tort reforms that could, potentially, mitigate the MMLI price and availability problems.

Alternative dispute resolution. This category would have included reviewing such alternatives as mandatory mediation models or voluntary binding arbitration initiatives. Although there was some interest in arbitration alternatives, the fact that Montana has had the Montana Medical Legal Panel since 1977 seemed to make further examination of the topic largely unnecessary. Nevertheless, the Subcommittee entertained discussion of at least one proposal to substantially revise the Montana Medical Legal Panel Act. No recommendation is made in regard to the Panel.

Insurance reform. Included under this heading might have been such matters as bad faith; alternative insurance products; and insurance company regulation. Although the Subcommittee did not scrutinize all aspects of this category, the Subcommittee's recommendations reveal that certain insurance reforms, reforms that are not related to "tort reform" were seriously considered.

In order to maximize the likelihood of the Subcommittee achieving successful outcomes from the SJR 32 study, the members exerted their attention on the nature and scope of the crisis in *Montana*,⁵⁹ but did so while simultaneously reviewing what was going on elsewhere. During the summer of 2003 and continuing through May 2004, the Subcommittee's staff compiled and provided to the Subcommittee information comparing states'

⁵⁹ Although the Subcommittee did not articulate a consensus on the causal relationships between various factors and the MMLI crisis in Montana and, subsequently, on the ability of state policymakers to effect positive changes in the causal factors in Montana, the recommendations suggest that there was at least some level of agreement, particularly in the areas of additional tort reforms—as evidenced by LCs 5001, 5002, 5004, 5005, 5007, and 5008—and alternative insurance products—as evidenced by LCs 5000 and 5009.

medical liability environments and legal liability reforms. The two most comprehensive compilations of liability environments and reforms were developed, independently, by the National Conference of State Legislatures (NCSL) and the American Medical Association (AMA). Each of the compilations covers all 50 states and there is some overlap among the legal or reform categories included. However, there are also categories unique to each collection.⁶⁰ The two documents provided much of the information repeated or summarized in this chapter.

Two specific areas of legislative interest characterized in SJR 32 were the recent experience with and alarm from increasing rates for MMLI and the public policy options potentially available to address the perceived price and availability problems.

This installment of the report focuses on the directive from SJR 32 that the study examine "measures adopted by other states to address the liability insurance problems related to liability insurance for health care facilities and health care providers associated with health care facilities".

The information that follows is presented in two parts: (1) Montana's medical liability law and reforms; and (2) policy alternatives. The first category of information summarizes current Montana law and practice. The second category of information summarizes some of the legal alternatives for addressing or resolving medical liability issues.

The objectives of the remainder of this chapter are twofold. First, because SJR 32 directs the Subcommittee to assess factors affecting the cost of liability insurance and because there are both perceptions and assertions

⁶⁰ The NCSL effort and the AMA collection are each included herein, respectively, at Appendix D and Appendix E.

that the status of a state's tort law may be or is a driver of insurance premiums in that state, the first part of the report attempts to articulate or clarify the status of tort law and tort reform in Montana, both individually and with respect to other states.

Second, because SJR 32 also directs the Subcommittee to examine measures adopted by other states to address liability insurance problems, strategies for increasing availability of affordable liability coverage, and strategies for resolving liability claims outside of the court system, the second category of information summarizes some alternatives adopted by or under consideration in some other states. Additionally, alternatives identified by individuals, academics, associations, et al., are also discussed in furtherance of the SJR 32 objectives.

Part 1: Montana Medical Liability Law and Reforms

Montana fairs [sic] very well in the category of enactment of "tort reform" measures, especially when compared with the states on the American Medical Association list of states that are "OK" in terms of the cost and availability of medical liability insurance, including a comparison with California, the claimed "Gold Standard" of tort reform. Montana fairs [sic] well both in terms of the type of legislation and the quality of legislation...

*Year 2003 Montana Medical Legal Panel Report
Executive Summary, February 13, 2003*

Montana's law regarding medical liability was in a state of transition from about the late-1980s through the mid-1990s. In part, longstanding practices and traditions were actual or perceived impediments to the welfare of Montana citizens, medical providers, and medical facilities. Then in 1995, during the 54th Legislative Session, the state's medical liability statutes were substantially revised to reflect policies adopted in other states, particularly

California.⁶¹ Since then, Montana's Legislatures have mostly left medical liability statutes alone—except, perhaps, when legislators perceived that the Supreme Court had subverted legislative policy.

In short, Montana's medical liability statutes currently reflect policies that are strongly advocated by medical practitioners, medical facilities, and medical liability insurers. Compared to other states, Montana's statutes now rank among the elite. Montana statutes reflect a philosophy that:

- an injured party should be fully compensated—no more, no less—for all actual damages and sufficiently compensated for noneconomic damages;
- responsibility for damages should be determined and assessed on a proportional basis among those responsible for the injury;
- medical practitioners, medical facilities, and insurers should have some confidence in the predictability of liability insurance premiums and availability at a reasonable cost; and
- public policy should not result in adverse consequences for citizens, medical practitioners or facilities, or insurers and should, whenever possible, act as a catalyst to reduce unpredictability, stabilize or reduce liability insurance rates, increase the availability of insurance, and enhance the image of Montana as a great place to practice or provide medical services.

Statute of Limitations: 27-2-205, MCA

Montana law requires a plaintiff in a medical malpractice action to commence the action within 3 years after the date of injury or within 3 years after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs last, but in no case may an action be commenced after 5 years from the date of injury.⁶² However, for

⁶¹ See House Bill No. 309, Ch. 461, Laws of Montana 1995.

⁶² This time limitation is tolled for any period during which there has been a failure to disclose any act, error, or omission upon which an action is based that is known to the defendant.

death or injury of a minor who was under the age of 4 on the date of the minor's injury or death, the period of limitations begins to run when the minor reaches the minor's eighth birthday or dies, whichever occurs first.

Underlying arguments for a statute of limitations, such as is in 27-2-205, MCA, include providing some assurance of a cause and effect relationship between the alleged act or omission and the injury claimed, as well as providing some predictability for practitioners, facilities, and insurers.

Underlying arguments against both a statute of limitations or a relatively brief statute of limitations include situations in which the injury or its effects don't manifest until a significant period of time elapses, during which the injured party is unaware that the injury has occurred.

Limits on Noneconomic Damages: 25-9-411, MCA

In a malpractice claim or claims against one or more health care providers based on a single incident of malpractice, Montana law, since 1995, has limited an award for past and future damages for noneconomic loss to a maximum of \$250,000.⁶³ All claims for noneconomic loss deriving from injuries to a patient are subject to an award not to exceed \$250,000. If more than one patient claims malpractice for separate injuries, each plaintiff is limited to \$250,000 in noneconomic damages.

Underlying justification for limiting noneconomic damages relies heavily on the fact that all *economic* damages—past, current, and future medical bills, loss of future earnings, etc.—are completely covered, that noneconomic

⁶³ The \$250,000 limit is the same as California's limit established in 1975 and is the amount advocated by reform advocates at the national level. See President Bush's MMLI policy summarized on the Internet at URL <http://www.whitehouse.gov/news/releases/2003/01/20030116.html> and "AMA Chief Touts Tort Reform as Cure for Malpractice Woes" by Kevin Kemper in *BizJournals* online May 31, 2004, at URL <http://www.bizjournals.com/columbus/stories/2004/05/31/focus5.html>.

damages are difficult to value in economic terms, and that noneconomic damage awards can vary widely for similar injuries or that such awards can vary widely among different jurisdictions and even within the same jurisdiction.

Underlying arguments against limiting noneconomic damages include a recognition that the economic damages awarded to an injured party, although fully covered, may not reasonably value the worth of certain types of work, e.g., a homemaker, or cannot reasonably value the future lost wages of a child. Thus, economic damages can vary substantially for virtually identical injuries suffered by different individuals without the possibility of a corresponding variation in noneconomic damages that would, in essence, result in equal treatment among individuals in similar circumstances. Additionally, there are certain injuries, e.g., loss of sight, movement, or sexual function, and circumstances, e.g., extraordinary pain, suffering, etc., for which an arbitrary limit or cap may not seem to adequately compensate for the injury.

Collateral Source Rule: 27-1-308, MCA

In Montana, the law states that in a case in which the damages exceed \$50,000, the total damages must be reduced by the amount of prior payment from collateral sources that do not involve rights of subrogation. The judge—rather than the jury—applies the rule and is by the statute to effect the offsets.

The underlying argument for the collateral source rule is to preclude a claimant from receiving payment more than once for the same injury.

Against the rule the argument is that reducing an award by amounts contributed from collateral sources rewards those who are culpable or responsible for the injury or damages at the expense of the injured party.

Joint and Several Liability: 27-1-703, et seq., MCA

In Montana, if the negligence of a party to an action is an issue, each party against whom recovery may be allowed is, with exceptions, jointly and severally liable for the amount that may be awarded to the claimant.

However, each party that is negligent has the right of contribution from any other party whose negligence may have contributed as a proximate cause to the injury. An exception to the general rule occurs whenever a party whose negligence is determined to be 50% or less of the combined negligence of all parties determined to be negligent is severally liable only and is responsible only for the maximum percentage of negligence attributable to that party.

Another exception is that a party may be jointly liable for all damages caused by the negligence of another party if both acted in concert in contributing to the claimant's damages or if one party acted as an agent of the other.

The advisability for reforming the joint liability doctrine, which Montana did in 1995 and 1997, is predicated on the belief that determining liability should be a system of comparative fault in which persons are held responsible only to the extent to which they cause or contribute to the harm. Further, advocates argue that joint liability reform should apportion liability among all tortfeasors according to their equitable share of fault, rather than only among parties to the action. It is argued that without the reform solvent defendants have to pay for the liability of insolvent, immune, or settled parties. In short, the reform limits the exposure of a defendant with a "deep pocket".

In contrast, arguments against reforming the doctrine include limiting the ability of an injured party and making it more difficult for the injured party to fully recover due compensation for the injury incurred.

Periodic Payments: 25-9-412, MCA

A party to an action for a medical malpractice claim in which \$50,000 or more of future damages is awarded may request the court to enter a judgment ordering future damages to be paid in whole or in part by periodic payments rather than by a lump-sum payment. If such a request is made, the court must enter an order for periodic payment of future damages. The total dollar amount of the ordered periodic payments must equal the total dollar amount of the future damages without a reduction to present value. If the injured party dies prior to full payment of the award, the remainder of the award becomes part of the decedent's estate.

The arguments favoring periodic payments include the premise that guaranteed periodic payments, such as through an annuity, will ensure that the injured party will have resources available for the duration of the injury or the life of the injured party. This approach provides some assurance that the injured party will not become a burden to the public fisc. A periodic payment schedule also allows the party responsible for making payment to better plan and accommodate the payments, compared to a one-time or lump-sum payment.

First, in opposition to periodic payments, it is sometimes the case that the injured party may not survive to benefit fully from the award. In such cases, it is argued, the injured party is not only subjected to the injury that is the cause of action, but also to subsequent financial injury. Additionally, there is the argument that once the award is made the injured party should be given the full amount immediately as the award is considered to be full.

compensation *at the time the award is made* without having to adjust for or "crystal ball" the vagaries of future events, e.g., inflation.

Pretrial Screening: Title 27, chapter 6, MCA

Montana has a forum, the Montana Medical Legal Panel⁶⁴, and *mandatory* process established to prevent whenever possible the filing in court of actions against health care providers and their employees for professional liability in situations in which the facts do not permit at least a reasonable inference of malpractice. In cases in which malpractice is reasonably suspected, the Montana Medical Legal Panel makes possible the fair and equitable disposition of claims against health care providers without the complexities, expense, and time investment of the legal process.

The principal argument for pretrial screening is the same as the purpose of the Montana Medical Legal Panel; i.e., it gives both the injured and accused parties the opportunity to have an objective "outsider" consider and comment on the claim prior to investing time, effort, and money in a legal process that might be avoidable. For example, if the Panel determines that the claim is wholly without merit, the claimant may drop the issue without any further action. Alternatively, if the Panel believes that the claim is meritorious, the defendant may reconsider negotiating and settling the claim outside the legal processes.

Arguments against the process include the additional time and, potentially, money that it takes to have a claim adjudicated in court—time and money that plaintiffs frequently do not have. Additionally, there is the possibility that the claimant or the defendant, or both, might (mis)use the process only to

⁶⁴ There is also the Montana Chiropractic Legal Panel that screens claims of chiropractic malpractice. The forum and processes essentially parallel those of the Montana Medical Legal Panel. See Title 27, ch. 12, MCA.

preview or discover the strength of the evidence and arguments of the adversaries or the perceptions or conclusions reached by an objective deliberative body.

Expert Witness Rules: Rule 702, Montana Rules of Evidence

The Montana Legislature has not enacted a statute defining the qualifications of an "expert witness" in medical malpractice cases. Rather, the Supreme Court has ordered, by Rule, that:

if scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise.⁶⁵

This rule is identical to Federal and Uniform Rules (1974) Rule 702.

Montana's Rule states the two common-law standards required before an expert is allowed to give his or her opinion, each of which standards is found in existing Montana law.⁶⁶

Further, a party may require through interrogatories any other party to identify each person whom the other party expects to call as an expert witness at trial, to state the subject matter on which the expert is expected to testify, and to state the substance of the facts and opinions to which the expert is expected to testify and a summary of the grounds for each opinion. (See Montana Rules of Civil Procedure under Title 25, chapter 20, MCA.)

⁶⁵ Rule 702, Montana Rules of Evidence.

⁶⁶ See "Commission Comments" in Title 26, ch. 10, pt. VII, 702, MCA.

According to the NCSL, 31 of the 50 states have statutes that address "expert witness" designation. The various states' statutes range from fairly weak or vague⁶⁷ to fairly strong or definitive.⁶⁸

Arguments in favor of establishing qualifications of "experts" *a priori* include precluding claimants or their attorneys from filing frivolous claims or, at least, mitigating the frequency and severity of the filing of frivolous claims.⁶⁹

Arguments against specifying expert qualifications include the additional time and expense to the claimant involved in finding/hiring the expert, which some individuals perceive as barriers to due process of law.

Attorney Fees

Attorney fees or, rather, limiting attorney fees is another entry on the checklist of liability laws or reforms.

For a few of the most adversarial cases, a claimant may feel compelled to retain legal counsel or, ultimately, to file a lawsuit. Reportedly, many or most of these cases are taken by legal counsel on a "contingency fee" basis, in which the attorney is compensated only if the claimant/plaintiff receives an award. The amount of the contingent fee varies, but is typically at least 30%

⁶⁷ Under Illinois code (735.5-8), the plaintiff is required to provide an affidavit stating that a competent expert has been consulted. (*State Medical Liability Laws Table*, NCSL, 2003.)

⁶⁸ For example, the Michigan code requires that an "expert" must be a licensed health professional, practice in a similar specialty, be board certified (if required on the specialty) during the year preceding the action, and have clinical or academic experience in the specialty. A certificate of consultation must be filed with claim. (*State Medical Liability Laws Table*, NCSL.)

⁶⁹ However, without requiring extremely stringent qualifications, it is very unlikely that what may be perceived by the accused practitioners or facilities to be "frivolous" claims will not be pursued by the claimant. More likely, there will always be an expert to be found who will attest to the merits of the claim. (Conversation with Larry Riley, Esq., Montana Defense Trial Lawyers Association, September 2003.)

of the award depending on the complexity of the case and the level of the legal system at which the case is ultimately resolved.

With respect to medical malpractice claims, Montana has not enacted limits on attorney fees⁷⁰, whereas some other states have.

Arguments in favor of limiting legal fees include the fact that a sizeable portion of the compensation awarded to the injured party is paid to the claimant's attorney. Additionally, some interests contend that fewer claims would be filed or pursued if trial attorneys did not have the opportunity to recover (potentially) large sums as contingency fees.

Against placing limits on legal fees are arguments that injured, low-income individuals would be shut out of the legal process if not for attorneys who are willing to gamble their own time and resources on the possibility that an award or settlement will be won. Further, those opposed to limits counter that the amounts received for some, perhaps many, cases taken on contingency are insufficient to cover the cost incurred by the attorney for that case. Finally, opponents point to the significant legal resources available to medical providers and facilities: ample legal counsel (both quantity and quality); considerable financial resources for, e.g., discovery, expert witnesses, etc.; and the luxury of time, a commodity that many injured claimants have little of.

Contributory or Comparative Negligence or Fault: 27-1-702, MCA

The concept of contributory or comparative negligence or fault is closely associated with joint and several liability. Contributory negligence does not bar recovery in an action to recover damages for negligence resulting in

⁷⁰ In Montana, attorney fees in Workers' Compensation cases are limited under 39-71-613, MCA.

death or injury if the contributory negligence was not greater than the negligence of the person or the combined negligence of all persons against whom recovery is sought, but any damages allowed must be diminished in the proportion to the percentage of negligence attributable to the person recovering.

The arguments pro or con are essentially the same as the arguments for or against joint and several liability—essentially, by advocates, that liability should be borne in proportion to fault or, by opponents, that the injured party is potentially subjected to additional time and expense in order to gain compensation for the injury.

Vicarious Liability or Ostensible Agency: 28-10-103, MCA

The premise of vicarious liability or ostensible agency is that a person who causes, directly or indirectly, a second person to believe that a third person is employed by or is an agent of the first person is liable for damages caused to the second person by the third person even though the third person is not employed, *per se*, by the first person. The underlying premise of ostensible agency is also related to the concept of joint and several liability yet, on the surface, could seem to contradict the tenets of comparative fault.

Montana has recognized ostensible agency since the state's early days, having enacted the original statute in 1895 and leaving it unchanged since enactment.

As a factor in medical liability insurance, the Montana Supreme Court concluded that:

a hospital will be deemed to have held itself out as a provider of care unless it gives notice to the patient that it is not the provider of care and that the care is provided by a physician who is an independent

contractor and not subject to the control and supervision of the hospital⁷¹.

With respect to ostensible agency, proponents view the application of the tenet as a legitimate means to ensure that an injured person could be fully compensated for an injury incurred.

In contrast, opponents see little, if any, relationship between the person who actually causes the injury and a virtually uninvolved party who has merely contracted for the services of the party that caused the injury.

Prejudgment Interest: 27-1-210, MCA

In Montana, it has been a matter of statutory law for nearly 20 years and a judicial practice prior to enactment of the 1985 law that interest may be awarded "on any claim for damages awarded that are capable of being made certain by calculation", i.e., actual damages but *not* noneconomic damages, court costs, or attorney fees.

Arguments associated with prejudgment interest revolve around the concept of the time-value of money and the pecuniary effects of inflation.

Summary of Montana Medical Liability Laws and Tort Reforms

From time to time, Montana has been seen as a state in which liability was so liberally construed as to compromise the welfare of, in this instance, medical practitioners and facilities. And, similar to citizens in many other states, Montanans have witnessed the enactment, application, and revision of various legal elements that affect or are affected by the theoretical and practical implications of medical liability.

⁷¹ *Butler v. Domin* (2000 MT 312, 302 M 452, 15 P.3d 1189, 57 St. Rep. 1320 (2000))

For good, ill, or naught, past Montana Legislatures have responded to the previously reported "crises" in medical liability and general liability by adopting legislation that articulates public policy with respect to assignment of liability, protection from liability, just compensation, proportionate accountability/responsibility, and economic reality. Over the past 20 years or more, Montana's Legislatures have gradually enacted or revised the state's laws to mitigate what have reportedly been the most egregious legal liability pitfalls, gravitating to the point where Montana is now recognized, by some at least, to be as "medical liability insurance-friendly" as nearly any other state.⁷²

Part 2: Policy Alternatives

The final paragraph of Part 1 of this chapter could be interpreted to mean that whatever forces are driving the increasing prices of and decreasing availability⁷³ of medical liability insurance, Montana's tort law is *probably not* one of the factors. In fact, if the tort law policies advocated by, e.g., the American Medical Association, et al., truly have the results that the AMA predicts they should have, Montana's tort law should be acting to mitigate price increases and enhance the availability of medical liability insurance. Adoption of SJR 32 and testimony to the Subcommittee are evidence to the contrary.

⁷² See, e.g., Gerald J. Neely, G. Brian Zins, and Kathy Whitehead, *Year 2003 Montana Medical Legal Panel Report, Executive Summary*, March 17, 2003; *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, U.S. General Accounting Office, August 2003, p. 17-21 (GAO-03-836); *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, U.S. General Accounting Office, June 2003, pp. 22, 45 (GAO-03-702).

⁷³ Information provided by the Montana Insurance Commissioner shows that the number of insurers offering medical liability insurance has remained quite steady over the past several years, with some insurers exiting the market and others entering.

Thus, the Subcommittee looked at other alternatives to identify different changes in public policy to further promote liability insurance price reduction and availability or at least stability in both price and availability.

Certificate of Merit

A certificate of merit requirement would require a plaintiff to obtain an expert assessment of the claim at the outset of the suit. As characterized by Catherine T. Struve⁷⁴ :

Some 17 states currently impose certificate of merit requirements in medical malpractice actions. The goal in each state appears similar: to deter plaintiffs from filing meritless claims. Each state's certificate of merit provision requires the plaintiff to provide a certification that the case has been reviewed by an expert and that the expert has concluded there is some basis for the claim. Beyond this essential similarity, however, the provisions vary significantly.

The applicability of the certificate and the person who must certify the certificate content can and do vary from state to state. For example:

- does the plaintiff's "expert" certify that the claim is meritorious or does the plaintiff's attorney certify that an expert has reviewed the claim for merit?
- at what level of specificity is the standard of care required to be stated?
- at what level of specificity must the breach of the standard of care be stated?
- at what level of specificity must the breach of the standard of care be identifiable as the cause of the injury and be stated?

⁷⁴ *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, by Catherine T. Struve, for The Project on Medical Liability In Pennsylvania, Pew Charitable Trust, pub, Columbia University, c. 2003. The certificate of merit requirements applicable to medical malpractice actions exist in Colorado, Connecticut, Florida, Georgia, Illinois, Maryland, Michigan, Minnesota, Missouri, Nevada, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Texas, and West Virginia. (Struve, p. 48.)

- is there simply a requirement than the expert certify that the claim is not meritless or unjustifiable?

In her research, Struve found that the empirical evidence regarding the efficacy of certificate of merit requirements is scarce and that what evidence there is does not seem to support the "deterrence theory".⁷⁵

Relying on Struve's research, the Subcommittee was advised that any certificate of merit requirement should have components that: (1) are based on the goal of the provision; and (2) consider the potential adverse effects of such a requirement. Stipulating that some form of "screening out weak malpractice claims" is the goal of a certificate of merit, the legal requirement should require the plaintiff's attorney to attest that he or she has consulted an "expert" and the expert has reasonably determined that the defendant *negligently* caused the plaintiff's injury.⁷⁶

Among the potential adverse effects described for the Subcommittee is the availability of and access to information about the injury. While medical records may be available, the defendant or others may not be available for interviews. Further, legal restrictions to accessing medical records may preclude the timely review of relevant records.⁷⁷

Another adverse effect identified is the cost of obtaining a certificate. The expert will likely not render a professional opinion for free and even the plaintiff's attorney may require the plaintiff to pay for the expert "up front". Sometimes, one expert may be hired to obtain the certificate and another

⁷⁵ Ibid., p. 50.

⁷⁶ Ibid., p. 51.

⁷⁷ Ibid, pp. 51-52.

expert retained for trial, thus potentially doubling the expense.⁷⁸ Further, the Subcommittee was cautioned that requiring a certificate of merit as a prerequisite may violate a plaintiff's constitutional right of equal access to the courts⁷⁹, right to trial by jury⁸⁰, or right to equal protection.⁸¹

Although the Subcommittee was asked to recommend "certificate of merit" legislation and discussed the option at length, they did not recommend establishing a certificate of merit.

Screening Panels

Montana's medical legal panels were addressed previously in this report but fall within this category of "alternatives" nevertheless. The Subcommittee considered that Montana's current process could be revised to, for example, alter the composition of the panels, reduce or expand the time allowed for panel review or decision, revise the amount of discovery or types of evidence allowed, limit or expand the scope of findings, or (possibly) allow or require the findings, conclusions, and decision of the panel to be admissible at trial. The Subcommittee was also alerted that the efficacy of such panels, in general, is questionable and the limited research suggests "that panels have

⁷⁸ Ibid., p. 52.

⁷⁹ See, e.g., *Aldana v. Holub*, 381 So.2d 231 (Fla. 1980); and *Cardinal Glennon Mem. Hosp. v. Gaertner*, 583 S.W.2d 107 (Mo. 1979). (Cited in Struve, p. 57, footnotes 1 and 3.)

⁸⁰ See, e.g., *Mattos v. Thompson*, 421 A.2d 190 (Pa. 1980). (Cited in Struve, p. 57, footnote 4.)

⁸¹ See, e.g., *Hoem v. State*, 756 P.2d 780 (Wy. 1988). (Cited in Struve, p. 57, footnote 6.)

not brought much overall improvement in malpractice litigation"⁸²—*the experience of the Montana Medical Legal Panel notwithstanding*.⁸³

The Subcommittee was advised that studies on the effects that panels may have on the frequency and severity of claims are inconclusive, possibly because of the lack of empirical research. What little can be inferred from the research suggests that panels have little effect on either the frequency of claims or severity of claims paid.⁸⁴

In addition to the remaining questions regarding frequency and severity of claims, conclusions about the effects that panels have on insurance premiums are mixed. One longer-term (13 years) study found "no statistically significant effect on premiums for general practitioners or general surgeons (though it did find that panels were associated with a statistically significant reduction in premiums for obstetrician-gynecologists)."⁸⁵

Possible adverse effects of panels or of changes to Montana's existing panel were listed for the Subcommittee and included additional time/expense

⁸² *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, by Catherine T. Struve, for The Project on Medical Liability In Pennsylvania, Pew Charitable Trust, pub, Columbia University, c. 2003, p. 56.

⁸³ The Panel has concluded that "Montana's Medical Legal Panel—which "screens" medical liability claims as a pre-condition to any lawsuit—has produced and is directly responsible for one of the lowest, if not the lowest, rates of medical liability court cases in the United States. This is readily observable from the rate of lawsuits prior to the existence of the Voluntary Screening Panel that pre-dated the current Mandatory Panel, during the later period of no panel and during the period of the current Mandatory Panel, when contrasted with national and state studies of rates of lawsuits." (Gerald J. Neely, G. Brian Zins, and Kathy Whitehead, *Year 2003 Montana Medical Legal Panel Report, Executive Summary*, March 17, 2003, p.2.)

⁸⁴ *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, by Catherine T. Struve, for The Project on Medical Liability In Pennsylvania, Pew Charitable Trust, pub, Columbia University, c. 2003, pp. 60-64.

⁸⁵ Primary source of conclusion found in Zuckerman, Stephen, Randall R. Bovbjerg, and Frank Sloan. 1990. Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums. *Inquiry* 27(2):167-82. Cited in Struve, p. 65.

involved for final resolution, more expense involved in discovery, scheduling difficulties, and even "trying the case twice".

Ultimately, the Subcommittee determined that the legal panels have accomplished the intended policy objectives and, presumptively as a consequence, did not recommend changes.

Specialized "Medical Malpractice" Courts

The underlying premise for advocates of medical malpractice courts is that increasing the specialization and expertise among judges would be beneficial to all involved: plaintiffs, defendant-practitioners, and insurers. More judicial expertise in medical issues, it is argued, could enhance the speed and the consistency and coherence of outcomes. Additionally, expert judges might be better able to assess the qualification of "expert" witnesses or the "reasonableness" of awards for both actual and noneconomic damages, as well as provide other procedural and substantive benefits.

A corollary premise is that an expert judge can better determine the "standard of care" threshold than can a jury, that the standard of care is more a matter of law (within the judge's purview) than it is a matter of fact (with the jury's purview), and that, as a matter of law, judges' decisions in medical malpractice cases could set precedents for guiding physicians' subsequent conduct.

The Subcommittee was also alerted to adverse implications of specialized courts, including the cost to establish a separate judicial system within the existing system, the simple fact that there may be and typically is more than one legitimate approach to diagnosis or treatment that would or could be viewed to meet the "standard of care", and that the precedential value of

judges' decisions is questionable due to the rapid pace of change in medical knowledge, understanding, technology, therapies, etc.

The Subcommittee was warned that there is a risk of "politicizing" the medical malpractice bench. Struve notes that "Commentators have long pointed out that the more specialized a court is, the greater the incentives and opportunities for interest groups to seek to influence the court's decisions, both by lobbying to select judges who will favor the desired position and by exerting pressure on the court in connection with particular cases."⁸⁶ The risk of politicization is exacerbated if judges are elected.

A specialized court would, over time, narrow the perspectives of its judges by focusing their attention in only one area rather than expanding their vision among various areas. With narrower focus, specialized judges could become unaware of parallels to be drawn from other areas and potentially diverging from the larger body of law.⁸⁷

The cost implications accrue not only to the public fisc, but also to the plaintiffs—it is highly unlikely that the number of medical malpractice courts would equal the number of district courts or that a specialized court would be located as close to plaintiffs as district courts are. Additionally, fewer and more distant trial venues would increase costs for juries, including selection, expense reimbursement, etc.

To counter some of the potential disadvantages of a specialized court discussed above, Struve offers some provocative suggestions.

⁸⁶ *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, by Catherine T. Struve, for The Project on Medical Liability In Pennsylvania, Pew Charitable Trust, pub, Columbia University, c. 2003, p. 73.

⁸⁷ See, e.g., *ibid*, pp. 75-76, for a more complete discussion.

If trial judges lack skill in assessing the admissibility of expert testimony, judicial training sessions could improve their understanding of the scientific method, probabilistic evidence, and other relevant topics. If specialized judges remain desirable, a separate court is not the only way to provide them. A specialized medical malpractice division could be created within a particular county's Court of Common Pleas, and judges could rotate into and out of that division. This option could reduce the politicization and perspective-narrowing problems identified above, while providing an opportunity for judges to gain concentrated experience in malpractice litigation. A specialized division, moreover, would not force litigants to travel large distances in order to pursue medical liability claims.... Those concerned principally with variations in jury awards, rather than judicial competence, might consider other reforms that tackle the jury issue directly, such as benchmarks to guide damage calculations.⁸⁸

Expert Witnesses

Recognizing that the issue of expert witnesses in the context of Montana law also was touched upon previously, tort reform advocates point to unqualified "experts" being allowed to testify as one factor that leads to undesirable outcomes, not only disproportionate awards but even unjustified or unproved verdicts finding malpractice where none existed. There are at least two options available to address this concern: (1) establishing, perhaps by statute, qualifications for experts that are higher, stricter, more definitive, etc., than may currently be present; or (2) allowing the judge to select an ostensibly "neutral" expert, rather than the plaintiff and defendant obtaining their own experts whose respective neutrality may be questionable.

On their face, either option could be seen as a credible, objective move toward "finding the truth" and away from the traditional approach of simply pitting one expert against another. Furthermore, each option has suboptions to consider, e.g., a court-appointed "expert" to determine or evaluate the

⁸⁸ See, e.g., *ibid.*, pp. 80-81.

qualifications of (especially) the plaintiff's expert, or a court-appointed expert to sift through the complexities of the case or contradictory findings or testimony of other experts and objectively synthesize the expert testimony for the jury.

In a mini-reprise of the testimony on HB 695 (2003), the Subcommittee was encouraged to recommend a statute prescribing qualifications for experts in medical liability actions. The advocates' arguments prevailed in that the Subcommittee recommended LC 5008, establishing criteria that an "expert" must meet in medical malpractice litigation. The Legislative Council, after further review and discussion of LC 5008, did not concur in the recommendation and does not recommend LC 5008.

Jury Education⁸⁹

Rather than treat jury members as passive actors waiting to be persuaded by various experts, the Subcommittee was told that the court could act to inform juries of the rules of evidence prior to the trial actually beginning. There is also the possibility of providing instructions to the jury before, as well as after, testimony is given. Periodic summaries of evidence, key exhibits, etc., by the attorneys or the judge were also raised as alternatives that could potentially help jurors to separate the wheat from the chaff.

A possible downside of jury education is that additional time and expense would be a near certainty.

Variability of Jury Awards

To the extent that variability of jury awards is inherently undesirable or bad, providing legislative guidance in structuring how damages, particularly

⁸⁹ See, e.g., *ibid.* pp. 86-90.

noneconomic damages, are assessed is arguably an option.⁹⁰ Struve again identifies variations on the theme that could include the following:

- lawyers could be permitted to frame their arguments concerning damages around prior awards in cases they consider comparable;
- juries could be given one or more stylized scenarios and associated valuations to use as benchmarks in considering how much to award;
- awards could be set by means of "a matrix of values" that would award fixed damage amounts according to the severity of injury and age of the injured party;
- awards could be constrained by "a system of flexible floors and ceilings" that vary with injury severity and victim age;
- instead of arguing damages to the jury (which would only determine factual matters, e.g., malpractice), lawyers could be required to make a similar case to the judge (who would establish damages as a matter of law, not fact);
- any award that deviates materially from reasonable compensation would result in *remittitur* if the jury award is excessive.⁹¹

David Sclar and Michael Housman, writing in the *Harvard Health Policy Review*, point to emerging reform proposals that:

... would significantly alter the process for resolving claims, as well as physicians' relationship to malpractice liability, in some cases removing the physicians from the process entirely. These new reform proposals fall under four categories...: alternative dispute resolution, enterprise liability, selective no-fault malpractice compensation and clinical practice guidelines as the standard of care.⁹²

⁹⁰ This option is "arguable" due to the right to "full legal redress" provided under Art. II, sec. 16, Montana Constitution.

⁹¹ *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, by Catherine T. Struve, for The Project on Medical Liability In Pennsylvania, Pew Charitable Trust, pub, Columbia University, c. 2003, p. 88. (By implication, this options suggests that an inadequate award will result in *additur*.)

⁹² *Harvard Health Policy Review*, "Medical Malpractice and Physician Liability: Examining Alternatives to Defensive Medicine", by David Sclar and Michael Housman, Spring 2003, Vol. 4, No. 1; Internet URL: <http://www.hhpr.org/currentissue/spring2003/sclar-housman-e.php>.

Alternative Dispute Resolution

Alternative Dispute Resolution or ADR is an increasingly common approach to determining facts, assigning responsibility, assessing damages, or a combination. To date, ADR is not used extensively in medical malpractice cases but is becoming increasingly present in general liability. Relying again on the observations of Sclar and Housman:

Alternative Dispute Resolution (ADR) can come in many different forms that ultimately remove disputes from the judicial system and place them in the hands of one or more professional arbitrators, thus eliminating the jury. Some forms of ADR include arbitration, mediation, neutral evaluation and summary jury trials. In the case of arbitration, the decision can be non-binding in that a party can continue to pursue the claim within the legal system if he is not pleased with the result, or, on the other hand, the decision may be the arbitrator's, in which case the option of court appeal is limited. The decision to submit the case to binding or non-binding arbitration is voluntary, and must be made before the case has been heard. In the past, arbitration has been infrequently used to resolve malpractice claims, but extensively used in commercial settings, and it has been demonstrated to be less costly in resolving disputes.⁹³

Enterprise Liability

A common practice in general corporate law, "enterprise liability", is a relationship in which the corporation assumes liability for an employee's actions rather than the employee. Under this system as it would apply to medical liability, a hospital, clinic, partnership, LLP/LLC, or other enterprise would assume liability for any alleged malpractice committed by a physician

⁹³ Ibid. p. 2 on Internet version.

who works in the hospital, clinic, etc.⁹⁴ There are clear advantages to this approach according to Sclar and Housman:

The major advantage that enterprise liability poses over the medical malpractice trial system, as it is currently structured, is that it relieves the physician of personal liability.... Furthermore, it compels the healthcare institution to more closely monitor the care that is given to its enrollees, and to take responsibility for quality improvement.⁹⁵

Potential drawbacks to enterprise liability include the changes in the relationship between the physician and the facility. Almost certainly those changes would result in a reduced level of autonomy for the practitioner, both in the way that he or she prefers to practice medicine and in the manner in which he or she behaves as an employee rather than as a privileged physician.

One thing that would not change would be that a physician accused of malpractice would continue to have his or her diagnoses, actions, and professional judgment subjected to scrutiny and criticism, even though he or she would avoid personal liability if malpractice were found to have occurred.

Selective No-fault Liability

The concept of selective no-fault liability proffered for medical liability is not unlike the decades-old "workers' compensation" system. In theoretical terms,

⁹⁴ It is unclear in reading Sclar and Houseman whether or not enterprise liability coverage extends to everyone who works in the enterprise or only for those who work for the enterprise. This is an important distinction because most hospitals grant "privileges" to physicians to treat patients in the hospital, but many or most privileged physicians also have private practices of their own, as part of a group practice, a limited liability partnership, etc. Consequently, privileged physicians are not "employees" of the enterprise as is the case in the context of enterprise liability as it applies in the general corporate world. Noteworthy, however, is the situation in Billings where St. Vincents Hospital and the physicians with privileges there are bearing increasingly burdensome medical liability premiums contrasted with the Deaconess Billings Clinic which "employs" the majority or all of its physicians and may not be suffering the equivalent level of premium pain that other medical facilities or physicians endure.

⁹⁵ Ibid, *Sclar and Housman*, p. 3 on Internet version.

a no-fault system would replace the fault-based tort liability system with a list of adverse outcomes from medical care for which claimants/victims would be compensated for economic loss, regardless of the acts or omissions of a medical practitioner or facility. The list would be limited to "avoidable classes of events" or ACE, and to each ACE would be attached a mechanism for determining compensation. Victims of ACEs would be automatically compensated merely as a result of the injury and without any finding of fault.

Selective no-fault liability is limited in practical application, however, because it would be impossible to identify, catalog, evaluate, and appraise the economic value of every conceivable ACE in every conceivable set of circumstances.

Florida has adapted a very specific version of "no-fault" with its NICA program (Neurological Injury Compensation Association). Created in 1988 at the height of Florida's last malpractice insurance crisis, the NICA program is designed to stabilize the insurance market against catastrophic birth-related injury claims, ensure that most of the payments go to patients instead of lawyers, both plaintiff and defense, and provide reasonable benefits to the injured child's parents. Under fairly rigid criteria, outside medical experts scrutinize a potentially eligible child's medical records prior to determining a NICA award or benefit.

The *Palm Beach Post* reported⁹⁶ that fewer than 175 children have been covered by NICA since 1988. The report also cited a study conducted by faculty at Duke University and Vanderbilt University that concluded that under NICA, "beneficiaries broke even" while families that received awards through tort settlements were "overcompensated". Notably, NICA does not

⁹⁶ "Malpractice alternative pays less", *PalmBeachPost.com*, June 15, 2003, Internet URL http://www.palmbeachpost.com/business/content/business/insurance_myths_061503.html

account for a child's lost income, typically seen as an actual damage. In contrast, tort settlements and verdicts typically do indemnify for a child's lost income.

Clinical Practice Guidelines

One of the more forceful propositions, clinical practice guidelines or CPGs, take the concept of "standard of care" to a somewhat higher level in which the standard is specifically laid out in a volume of guidelines. If adopted, typically through legislation, CPGs would immunize physicians from suit provided that the applicable CPGs were followed, even where the clinical outcome was adverse to the patient. Sclar and Housman are clear in their description of perceived advantages of CPGs:

... clinical practice guidelines actually provide physicians with guidance on which medical practices are beneficial to the patient and which are either wasteful or potentially harmful. In this respect, CPGs have the potential to end clinical practices that began for defensive reasons and have long since become ingrained in the physician's mentality as the standard of care. Furthermore, court admission of the clinical practice guidelines ensures that clinical standards are the basis for determining cases. They may therefore eliminate the need to solicit testimony from expert witnesses who can carry widely divergent opinions regarding appropriate medical practice...⁹⁷

Among the potential disadvantages of CPGs, Sclar and Housman are just as clear.

Drafting and applying clinical practice guidelines are not yet perfect processes, and face a number of challenges. Clinical guidelines must leave room for physician discretion since real-life clinical scenarios are rarely black and white. The uncertainty in medicine makes CPGs difficult to create for certain treatments and procedures in which the standard of care is unclear. Furthermore, it becomes difficult to create

⁹⁷ Ibid. *Sclar and Housman*, p. 3 on Internet version.

clinical guidelines for every procedure imaginable, so there will certainly be some malpractice trials for which clinical guidelines are unavailable and proceedings revert to reliance on expert testimony and subjective judgments about malpractice. Consequently, the use of clinical guidelines may be limited, and may therefore only have an impact on certain cases of malpractice litigation.⁹⁸

Insurance Market Interventions

Insurance market interventions are identified by the National Governor's Association as "stopgap solutions that address the lack of affordable or available insurance, such as providing subsidies to providers or creating state-run insurance programs. These measures typically are thought of as short-term or providing an option of last resort and may not solve the systemic issues that insurers and providers believe exist in the medical liability insurance market."⁹⁹ The following descriptions, as compiled and summarized by the National Governor's Association, outline several insurance market interventions:

- **State-Run, Stop-Gap Medical Malpractice Liability Coverage.** The state establishes its own insurance fund from which doctors can purchase insurance if there is no other insurance carrier on the market. Typically overseen in the department of insurance and administered by a third party administrator, these funds try to relieve the immediate crisis and provide immediate relief to physicians unable to find affordable insurance. **Nevada and West Virginia** established state-based medical malpractice insurance funds in 2002 in order to relieve the current shortage.... The benefit of this type of fund is that it solves the immediate shortage of available insurance but not always of affordable insurance. In addition it is difficult to price premiums that are affordable without putting the state at risk for being the sole insurer in the state. In West Virginia, the state was required to price premiums

⁹⁸ Ibid.

⁹⁹ *Issue Brief: "Addressing the Medical Malpractice Insurance Crisis"*, Emily V. Cornell, National Governor's Association, December 5, 2002

higher than what was available in the commercial market in order to not compete with the commercial market.

- State Patient Compensation Programs. Patient compensation funds spread the cost of high awards more broadly. The state creates a fund that pays the portion of a judgment or settlement against a health care provider that exceeds a designated amount— such as \$200,000 per occurrence and \$600,000 annually. The fund pays the remainder of the award or it may have a maximum—such as up to \$1 million. The provider is responsible for awards beyond the funds' maximum unless a corresponding limit on medical liability applies. These funds are funded through an annual surcharge assessed against healthcare providers that participate in the fund, and participation can be mandatory or voluntary. Seven states—**Indiana, Louisiana, Nebraska, New Mexico, North Dakota, South Carolina, and Virginia**—operate voluntary systems, and three states—**Kansas, Pennsylvania, and Wisconsin**—operate mandatory programs. Since patient compensation funds help spread the risk more broadly, they help maintain the availability of medical malpractice insurance. However, it means that health care providers may pay two premiums for malpractice insurance, and therefore does not address the affordability issues.
- State Subsidies to Providers. The state establishes a mechanism that subsidizes all or a portion of the provider's insurance premium. This type of system could be set up as a one-time fund or continue for a limited number of years until insurance premiums stabilize. Subsidies could be made available to all providers, to a select group of providers who practice in high-risk specialties, or to providers in a select medically underserved geographical area within a state. Subsidies are simple to administer and easy to sell politically, especially if they are targeted to providers in a geographically underserved area. However, they do not address the underlying reason for high premiums. **Arizona, Hawaii, Illinois, Louisiana, Maine, Nevada, New York, North Carolina, Texas, and Washington** have tried this approach in the past to solve an immediate crisis. These programs were established in the late 1980s and abandoned as the liability crisis abated.
- Joint Underwriting Associations. A Joint Underwriting Association (JUA) is a state sponsored association of insurance companies formed with statutory approval from the state for the express purpose of providing certain insurance to the public. JUAs

are usually formed because the voluntary market is unwilling to write coverage. The advantage of a JUA is that it spreads the risk across several companies, instead of one. They may cease when the voluntary market becomes available for that line of business. JUAs address the lack of insurance. However, insurance from a JUA typically is more expensive than from the private market, since it is the insurer of last resort, particularly for high-risk specialties who have no other choice.

- Physician Insurer Associations or Physician Mutual. Physician insurer associations are physician owned and operated insurance companies that provide medical liability [insurance]. These insurance companies began in the 1970s during the first medical liability crisis. Doctors, with the support of medical and hospital associations, contributed their own funds as capital to start as many as 100 provider-owned specialty carriers across the country. They have been dubbed “bed pan mutuals” by their commercial competitors. Currently, physician insurance companies insure over 60 percent of the nation’s practicing physicians. Physician insurer associations create other carriers in the market to provide malpractice insurance and therefore address access to insurance for physicians. However, there is no indication that these types of insurance carriers are immune from the same issues that have driven out other commercial insurance carriers.
- State-Funded Indemnity for Specific Services. State-funded indemnity offers liability coverage for providers who typically have a relationship with the state—either through the state university hospital or another type of public hospital system—and who provide critical emergency services. A state indemnity program typically covers a claim against a physician when the physician is working directly for a city, county or state and/or providing specific services such as trauma or obstetrical. The liability is shifted from the provider to the government, and all claims are brought against the state rather than the provider. This option address helps cover providers who serve low-income populations and target liability protections to the groups of providers that have been hardest hit. However, there is the risk that the state becomes the deep pocket in malpractice cases.

Another option, *captive insurers*, is not discussed in detail here. (A captive insurer is so named because it is owned by the insureds.) Montana has adopted legislation authorizing the creation and operation of captive insurers,

and several have been created. During the course of the study, several Montana hospitals were pursuing the creation of a captive insurance company for self-coverage.¹⁰⁰ Staff at the Office of the Insurance Commissioner confirm that the captive company has been established.¹⁰¹

Insurance Reform: California's Proposition 103

Aside from the insurance market interventions discussed above, there are other insurance reforms available to public policymakers. Prominently among them is Proposition 103-type reform. California's Proposition 103 is a 15-plus-year-old initiative composed of six primary elements. It:

- mandated an immediate rollback of rates of at least 20%—rate relief to offset excessive rate increases by establishing a baseline for measuring appropriate rates.
- froze rates for one year. Ultimately, because of the delay caused by insurance company legal challenges to Proposition 103, rates remained frozen for four years pursuant to decisions by the state's insurance commissioner.
- created a stringent disclosure and “prior approval” system of insurance regulation, which requires insurance companies to submit applications for rate changes to the California Department of Insurance for review before they are approved. Proposition 103 gives the California Insurance Commissioner the authority to place limits on an insurance company's profits, expenses and projections of future losses (a critical area of abuse).
- authorized consumers to challenge insurance companies' rates and practices in court or before the Department of Insurance.
- repealed anti-competitive laws in order to stimulate competition and establish a free market for insurance. Proposition 103 repealed the industry's exemption from state antitrust laws, and prohibited anti-

¹⁰⁰ Testimony of Claudia Clifford, Office of the State Insurance Commissioner, in *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, September 22, 2003.

¹⁰¹ Communication with John Huth, Office of the Insurance Commissioner, September 2004.

competitive insurance industry "rating organizations" from sharing price and marketing data among companies, and from projecting "advisory," or future, rates, generic expenses and profits. It repealed the law that prohibited insurance agents/brokers from cutting their own commissions in order to give premium discounts to consumers. It permits banks and other financial institutions to offer insurance policies. And it authorizes individuals, clubs and other associations to unite to negotiate lower cost group insurance policies.

- promoted full democratic accountability to the public in the implementation of the initiative by making the Insurance Commissioner an elected position.¹⁰²

The proponents of Proposition 103 remain foursquare behind the initiative and, irrespective of California's MICRA¹⁰³, contend that:

... the most effective way to protect consumers and ensure reasonable insurance rates is through the tools of a prior approval insurance regulation system. Our research has shown that insurance company regulation, when properly implemented, can save consumers billions of dollars and maintain profitability within the insurance industry, thereby providing customers with the most choice in the market. In other words, the regimen of insurance regulation creates the environment that is most conducive to marketplace competition while also affording consumers necessary protection against insurance company profiteering....

Proposition 103 worked. Insurance companies refunded over \$1.2 billion to policyholders, including motorists, homeowners and doctors. In the closely studied area of auto insurance, California was the only state in the nation in which auto insurance liability premiums actually dropped between 1989 and 2001, according to NAIC data. A 2001 study by the Consumer Federation of America concluded that the prior

¹⁰² Excerpt from "Proposition 103: A Model for Insurance Regulation", Testimony of Douglas Heller, Foundation for Taxpayer and Consumer Rights, Before the Committee on Commerce, Science and Transportation, United States Senate, Washington, D.C., October 22, 2003.

¹⁰³ Medical Injury Compensation Reform Act of 1975 (California; MICRA 1975).

approval provision of Proposition 103 blocked over \$23 billion in rate increases for auto insurance alone through 2000.¹⁰⁴

Montana does not have statutory provisions similar to California Proposition 103, but likely could enact something similar. A summary of Proposition 103 is included at Appendix F.

Other Potential Reforms

Testifying before Congress in October 2003 on behalf of the organization Public Citizen, Mr. Douglas Heller outlined seven discrete alternatives that would address some of the medical liability issues identified in SJR 32 and provide additional information or protection to the public. Heller's proposed reforms appear below.¹⁰⁵

Reform medical board governance. States should sever any remaining formal, debilitating links between state licensing boards and state medical societies. Members of medical boards (and separate disciplinary boards, where present) should be appointed by the governor, and the governor's choice of appointees should not be limited to a medical society's nominees. At least 50 percent of the members of each state medical board and disciplinary board should be well-informed and well-trained public members who have no ties to health care providers and who, preferably, have a history of advocacy on behalf of patients. The governor should appoint members to the Medical Board whose top priority is protecting the public's health, not providing assistance to physicians who are trying to evade disciplinary actions.

Beef up medical board funding and staffing. State legislatures should permit medical boards to spend all the revenue from medical licensing fees, rather than being forced to give part to the state treasury. The medical boards should raise their fees to \$500 a year. All boards could benefit from hiring new investigators and legal staff. Boards should employ adequate staff to process and investigate all complaints within 30 days, to review all malpractice claims filed with the board, to monitor and regularly visit doctors who have been disciplined to ensure their compliance with the sanctions imposed, and to

¹⁰⁴ *Op. cit.*, Heller, p. 3.

¹⁰⁵ www.citizen.org/congress/civjus/medmal/articles.etm.ID=8308.

ensure compliance with reporting requirements. They should hire investigators to seek out errant doctors, through review of pharmacy records, consultation with medical examiners, and targeted office audits of those doctors practicing alone and suspected of poor care.

Require risk prevention. States should adopt a law, similar to one in Massachusetts, that requires all hospitals and other health care providers to have a meaningful, functioning risk prevention program designed to prevent injury to patients. Massachusetts also requires all adverse incidents occurring in hospitals or in doctors' offices to be reported to the medical board.

Require periodic recertification of doctors based on a written exam and audit of their patients' medical care records.

Institute experience rating. Doctors should be rated on performance for malpractice premiums. Doctors with numerous malpractice claims must be reviewed and higher premiums imposed so that they are discouraged from practicing and competent doctors do not subsidize them.

Spread the risk more broadly. The number of classifications of doctor specialties for insurance rating purposes should be reduced. Risk pools for some are too small and thus overly influenced by a few losses and the concentration in a few specialties of doctors handling the highest risk patients. Often the high-risk patients are "referred up" from general practitioners who do not bear any of the risk.

The Specific Case of Wisconsin and Medical Liability

On January 15, 2004, the SJR 32 Subcommittee asked its staff to prepare and present an overview of the Wisconsin Health Care Liability and Patients Compensation Act (HCLPCA or Act), enacted in 1975. The narrative that follows describes the primary components of the Act in a question-and-answer format. The statutory language of the Act is codified at Chapter 655, Wisconsin Statutes, and is available online at <http://folio.legis.state.wi.us/>, then follow the links.

What is the Wisconsin HCLPCA? The Act is composed of two primary parts. One part establishes a liability environment for "health care" that is materially and procedurally different from Wisconsin's general liability environment. The other part establishes an environment for compensating patients who

are injured as a result of malpractice that is materially different from Wisconsin's general liability environment.

The second part, the liability program established by the Act, is a mandatory excess insurance program that supplements but does not replace the existing, private, medical malpractice insurance marketplace. The program provides higher limits of liability insurance to health care providers and facilities than might otherwise be available or affordable. The liability program also requires and restricts certain actions by the parties affected by medical liability claims. In common parlance, these actions are referred to as "tort reforms".

The compensation program, manifested in the Patients Compensation Fund (PCF) and the processes associated with it, adds "capacity" to the liability insurance market and enables existing medical malpractice carriers to sell more policies. The logic underlying the program is: If the existing carriers do not have to allocate capital to sell higher limits of coverage, they can allocate that capital to sell more policies.

As briefly as is practical, the Act:

- establishes liability insurance requirements and restrictions on medical providers, medical facilities, and medical liability insurers;
- establishes requirements and restrictions on malpractice claimants, including their representatives and heirs;
- limits the remedy for malpractice exclusively to the provisions of the Act;
- establishes processes for making and resolving malpractice claims;
- establishes limits on attorney fees payable for malpractice claims;
- establishes procedures for the management, by a public entity, of compensation paid to a claimant for medical costs that result from malpractice by a medical provider or facility;

- imposes limits on noneconomic damages payable for malpractice;
- establishes procedures for setting fees to sustain and operate the patients compensation programs;
- disallows a medical practitioner or facility from rejecting a settlement agreed to by an insurer and claimant;
- precludes an insurer from canceling or not renewing a liability policy, except in certain circumstances;
- requires medical liability insurers to file monthly reports on the details of each claim paid during the previous month;
- creates a "patients compensation fund" designed to compensate, in certain cases, certain claimants who have suffered from malpractice and to protect medical providers, facilities, and insurers from unusually large claims payments;
- establishes and provides for the administration of the Act, particularly the PCF;
- establishes processes for postclaim award review and mediation;
- requires various reports from various entities at various times for various purposes;
- establishes and provides for the administration of a "mediation fund", which essentially is an appendage of the Act.

Who is affected by the provisions of the Act? There are basically two categories of persons who are affected by the provisions of the Act. The first category includes all (except as described below) of the following in Wisconsin: physicians, nurse anesthetists, any partnership composed of physicians or nurse anesthetists, or both; any corporation organized and operated in Wisconsin for the primary purpose of providing the medical services of physicians or nurse anesthetists, or both; any cooperative sickness care association that operates a nonprofit sickness care plan in Wisconsin and that directly provides services through salaried employees in its own facility; any ambulatory surgery center that operates in Wisconsin; any hospital that operates in Wisconsin; any entity operated in Wisconsin that is an affiliate of a hospital and that provides diagnosis or treatment of or care for patients of the hospital; and any nursing home whose operations are

combined as a single entity with a hospital, whether or not the nursing home operations are physically separate from the hospital operations. (However, this category does not include: a physician or a nurse anesthetist who is a state, county, or municipal employee, or a federal employee or contractor covered under the Federal Tort Claims Act and who is acting within the scope of his or her employment or contractual duties.) Participation by active Wisconsin providers is mandatory. There are some providers for whom coverage is optional, e.g., Michigan physicians doing substantial business in Wisconsin.

The second category is composed of: any person/patient (or representative of a person/patient) who received or should have received health care services from a health care provider or from an employee of a health care provider acting within the scope of his or her employment if the person makes a claim; or any spouse, parent, minor sibling or child of the person/patient, which spouse, parent, minor sibling or child of the person/patient has a derivative claim for injury or death on account of malpractice. All claims made are subject to the provisions of the Act.

Why was the program created? The program was created in 1975 as a response to the first medical malpractice insurance crisis. Events at that time disrupted the lives of physicians and the people they serve in ways similar to disruptions reportedly occurring nowadays in various jurisdictions.

Market disruptions that were occurring in the 1970s were likely due, in part, to economic conditions and to the tort system. Medical providers and facilities in Wisconsin and many other states had experienced a "hard" liability insurance market—providers and facilities could not afford or in some cases even buy the insurance they needed.

The market disruption was partially a result of the economic law of supply and demand. The insurance industry did not have the capacity to supply enough insurance at affordable prices to meet the needs of health care providers. The program was established to immediately expand access to insurance and to provide, in the longer term, a reliable source of insurance capacity.

How did the program create additional malpractice insurance capacity? The program, through the PCF, is an excess insurance or reinsurance program. The PCF pays for claims that exceed a certain dollar threshold. By launching an insurance program to cover the high end of a claim, the state infused new capacity into the system. The program relieved the existing market of the pressure to reserve for the most expensive claims and, thus, additional capacity was created immediately in the existing market. Since its inception in 1975, the PCF has continued to provide liability insurance capacity above what there would be absent the program.

What level of insurance coverage does the program provide? Under Wisconsin law (April 2003), health care providers must obtain primary medical malpractice insurance from private insurance companies in the amount of \$1 million per occurrence and \$3 million per policy year in the aggregate. (A self-insured provider must have a minimum of \$800,000 of primary coverage.) The PCF provides coverage in excess of the primary insurance and PCF coverage is unlimited.

How does this program stabilize the medical malpractice marketplace? The Wisconsin program initially provided an immediate increase in capacity and continues to provide some added level of capacity with respect to higher limits of coverage. The private market in Wisconsin is no longer wholly

dependent on the ability of domestic and international reinsurers to provide excess coverage.

In the past, capacity for excess insurance was driven by economic conditions beyond Wisconsin's borders that cause fluctuations in the worldwide insurance marketplace. At times, reinsurers essentially dictated who primary insurers can cover, the prices primary insurers charge, and the coverage primary insurers provide. The PCF allows medical liability insurers and their insureds in Wisconsin to affect, at some level, pricing and coverage decisions.

Importantly, the primary effect (and goal?) of the program has been to increase the availability of liability insurance. The price of liability insurance, especially for primary coverage, is still market-driven.

How is the Wisconsin PCF capitalized? Initially, the PCF was not capitalized. Rather, it operated on a cash basis during its first 5 years of existence. (The State of Montana's self-insured general liability insurance program currently operates on a cash basis.) During the 1980s, the PCF switched from cash accounting to accrual accounting to improve the integrity of the fund. Under the accrual method, providers are assessed an amount that is based on estimates of what all claims would total over time for incidents that occurred in any given year, rather than on what the payout amount was for that year. Accrual accounting ensures that the PCF has sufficient assets to pay all outstanding liabilities, including claims incurred but not reported, if the PCF were discontinued. The estimates of what claims would total over time are actuarially determined. Wisconsin requires insurers to be financially solvent such that their assets are sufficient to cover any outstanding liabilities. Therefore, if an insurer stops doing business, all outstanding claims against the insurer will be paid. The PCF is currently operated in a similar manner.

Does the Wisconsin program affect the price of malpractice insurance? In total, the programs may affect liability insurance premiums but, ultimately, any effect on pricing may be unknowable. At best and to the extent that pricing is affected, which aspect of the entire program accounts for which portion of any pricing effect is elusive.

The programs created by the Act are multifaceted and include components about which some advocates and some opponents fundamentally disagree. For example, the Wisconsin program includes many elements that tort reform advocates hail as economically vital and that consumer advocates assail as false prescriptions or red herrings. The programs' other elements—(medical) jurisprudence reforms, medical practice reforms, insurance reforms—also have their own advocates and detractors and may or may not have incremental effects on MMLI pricing.

Is the program simply a bonus for special interests? Medical providers and facilities and medical liability insurers are the most obvious and directly affected beneficiaries. To the extent that any of those groups is a "special interest", the program may be a bonus. However, to the extent that liability insurance and tort law affect access to and the cost of medical care, there are numerous others who benefit indirectly, with the potential that everyone who receives or merely has access to medical care in Wisconsin receives some residual bonus. Consequently, distinguishing the special interests from within the general interest is both personal and difficult.

On the flip side of the special interest coin, persons injured through medical negligence may be denied something perceived to be "full compensation" for the negligent acts of medical providers or facilities. Reinsurers may miss out on lucrative business. Attorneys may forego income due to caps on contingency fees. Medical providers and facilities forego their freedom of

choice regarding excess liability coverage, both from whom it is purchased and at what level of coverage. The insured, the insurers, and injured persons are all compelled to follow laws and procedures that they may not particularly like or believe in, and so on.

How financially healthy or stable is the PCF? According to a report from the Wisconsin Legislative Fiscal Bureau staff,¹⁰⁶ the PCF had approximately \$588 million in assets and about \$582 million in estimated liabilities at the end of fiscal year 2002. The report also stated that the amounts contemplated to be payable for current but unsettled claims and future claims had historically exceeded actual claims by a significant amount. That fact has also caused the Board of Governors of the PCF to regularly set annual assessments for providers and facilities at levels considerably less than the amounts recommended by the actuary. In the most recent year reported, the actuary had recommended an increase of 117.4%, but the Board set the increase at only 5%.¹⁰⁷ (Of the nine fiscal years from 1994-95 through 2002-03, the Board commonly set assessments 10 percentage points or more below the levels advised by the actuary.) Considering the PCF had at FY 2002 yearend a positive equity of approximately \$6 million, particularly given previous Boards' actions in setting assessments, it appears that the PCF is relatively healthy and stable.

Are the citizens of Wisconsin on the hook to pay claims? As the program is designed statutorily, Wisconsinites are not on the hook to pay claims. The legal framework of the program has created, ostensibly, a quasi-private insurance entity that is removed from direct agency with the State of Wisconsin. The entity does not act as an agent of the state (as would a

¹⁰⁶ *Patients Compensation Fund*, Paper #458, by Kim Swissdorf, Wisconsin Legislative Fiscal Bureau, April 23, 2003.

¹⁰⁷ *Ibid.*, p. 5.

Department of Health employee, an elected official, or a contractor in their official capacity) and, theoretically, should not legally be treated as an agent of the state.

However, the State of Wisconsin, through the Board of Governors and the Insurance Commissioner each acting in their statutory capacity, is a party to the programs. Because the programs are a creation of the state, there may be at least a moral obligation for the state, i.e., taxpayers, to pay for outstanding liabilities if the PCF is ever unable to pay.

Is the Wisconsin approach unique? In many way, no; in some ways, yes. According to the Wisconsin Legislative Fiscal Bureau, there are eight states, plus Wisconsin, that have some type of a PCF. Of the nine "PCF states", participation by providers and facilities is mandatory in Kansas, Pennsylvania, and Wisconsin. Coverage is unlimited in South Carolina and Wisconsin. Wisconsin's primary coverage requirements of \$1 million per incident and \$3 million per policy year are higher than any of the other PCF states. Finally, Wisconsin is the only state that has both a mandatory participation requirement and unlimited coverage.

What options have other states pursued? Variations of the Wisconsin model include the ways in which liability coverage is provided and compensation is meted out and who manages the programs and how, to name only a few.

The "liability coverage" options include: whether the state's program is optional or mandatory; the coverage limits, e.g., \$1 million/\$3 million; and the allocation of the costs of the program, i.e., participants are assessed proportionately, uniformly, or by some other measure.

The potential processes to determine the amount of PCF compensation provided by programs include: "no fault" compensation (akin to workers' compensation); voluntary arbitration; mandatory arbitration; medical malpractice courts; various mechanisms for appeals; and others.

The options for determining the amount of compensation include: PCF coverage for a fixed-dollar maximum amount, e.g., the amount of the claim above the insured's private-policy maximum up to a maximum amount; PCF coverage for a fixed-percentage maximum amount, e.g. 50% of the amount of the claim above the insured's policy maximum up to a maximum amount; unlimited PCF coverage above the insured's private-policy maximum; and combinations of the above.

The options for managing the programs would include: variations of the independent "board" and "council" approach that Wisconsin uses; attaching PCF program management to an existing entity (e.g., the board of the state compensation insurance fund); establishing a new state entity in or assigning PCF program management to an existing state entity in the Executive Branch (for example, an office of insurance regulation); establishing an elected office, either an individual or a commission, to manage the program; or a combination of these or other alternatives.

The LC 5000 Option

The Subcommittee invested considerable time and energy in adapting the concepts contained in the Wisconsin Health Care Liability and Patients Compensation Act into a form believed to be technically, economically, theoretically, practically, and culturally doable for Montana. Penultimately, the Subcommittee settled on and recommended LC 5000. Conversely, the Legislative Council does not recommend LC 5000.

As recommended by the Subcommittee to the Legislative Council, LC 5000 deviates from the Wisconsin HCLPCA in at least two substantial ways. First, LC 5000 does not require doctors, hospitals, or other providers of medical care to carry any amount of primary liability coverage. Primary coverage is optional, at each provider's discretion. (Wisconsin requires minimums of \$1 million/\$3 million in primary coverage.) Second, LC 5000 sets \$500,000 as the threshold at which the Plan provides coverage for damages.¹⁰⁸ (The threshold in Wisconsin is \$1 million in damages.)

Another significant distinction between the Wisconsin HCLPCA and LC 5000 is the cap on noneconomic damages. In Wisconsin, the limit is adjusted annually for inflation based on the consumer price index. In LC 5000, the \$250,000 cap established by House Bill No. 309 (1995) remains intact and constant.¹⁰⁹

Summary of Montana MMLI Law, Other States' MMLI Laws, and Options

Montana has enacted various tort reforms over the past 20 years that place the state among the elite with respect to medical liability statutes. Even as California's MICRA is sometimes referred to as "The Gold Standard", Montana's law is substantially the same.¹¹⁰ Furthermore, if Montana is at or nearly at the gold standard of tort reforms, it should be difficult to conclude or argue that the status of Montana's tort law can have had anything but a

¹⁰⁸ From conversations between Sen. John Cobb and the author, the author infers that each of these provisions was proposed with the beliefs that the prices paid by medical providers for MMLI will be less than current prices; that the prices paid for MMLI will be more stable in the future, and that the availability of MMLI will be expanded.

¹⁰⁹ "Constant" is used here in the context that law is constant unless changed through the legislative process.

¹¹⁰ For a more detailed comparison, see "California vs. Montana: Detailed Comparison of Major Legal Provisions Related to Medical Malpractice" (Source: Medical Malpractice Summary, McCullough, Campbell & Lane, 205 North Michigan Ave., Suite 4100, Chicago, Illinois 60601-5925).

positive effect on medical liability premiums and the availability of medical liability insurance. Particularly with respect to premiums, however, it is difficult to articulate with any degree of confidence just what positive effects have resulted.

Aside from tort reform, different students of the medical liability insurance "crises" have identified or proposed various alternatives as partial solutions. These alternatives include: variations on elements of tort law; educating judges and juries; creating a specialized court; implementing tools for normalizing jury awards; several different approaches for "alternative dispute resolution"; no-fault liability; establishing clinical practice guidelines; several insurance market interventions; Proposition 103-type (CA) requirements, restrictions, and authority; reforming the state medical board; enhancing the existing medical board and its staff; requiring risk prevention and periodic recertification of doctors; instituting experience ratings in medical liability insurance practices; and spreading the risk of medical liability more broadly. All told, there are at least a couple dozen options listed herein that have been enacted by, considered in, or proposed to various states' legislatures. There are likely to be many others.

Fundamentally, policymakers must determine to their own satisfaction the cause(s) of rising medical liability insurance premiums and, if it exists in Montana, the declining availability of medical liability insurance. Only then can they enact public policies to remedy the concerns and problems.

5. A Measure of Success

Too frequently and most unfortunately, work done by interim committees is sometimes dismissed out of hand, particularly by those who are ignorant of a committee's efforts or those who may feel their ox was somehow gored as a result of the committee's actions. Although some similar carping may be directed at the work of the Subcommittee or the Legislative Council, any such comments can't legitimately be based on a contention that the Subcommittee or Council "didn't do anything".

To the contrary. The Subcommittee and the Council, independently, attempted diligently to address each of the issues identified in SJR 32:

- the rising cost of liability insurance for health care providers;
- a significant decline in the past few years in the number of insurance carriers that provide liability insurance for hospitals, clinics, and nursing homes;
- the hypothesis that dramatic hikes in the prices paid by hospitals, clinics, and nursing homes for liability insurance may be a major contributor to the escalation in the cost of providing medical treatment;
- the theory that increased premiums for liability insurance may be forcing physicians and other providers in Montana to consider curtailing certain medical services;
- that the State of Montana has a compelling interest in ensuring that affordable health care is available for its citizens, and a contention that stabilizing premiums for liability insurance for health care facilities and health care providers associated with health care facilities will contribute toward cost containment for health care for Montana citizens.

The study committee was also directed by SJR 32 to compile information seen to be relevant by the Legislature and to:

- review measures adopted by other states to address the liability insurance problems related to liability insurance for health care facilities and health care providers associated with health care facilities;
- identify or propose strategies for increasing the availability of affordable liability coverage, including alternative sources of liability coverage;
- identify factors affecting the cost of liability insurance for health care facilities and health care providers associated with health care facilities; and
- identify or develop strategies for resolving liability claims outside of the court system.

This chapter reviews information provided to the Subcommittee and the Legislative Council with respect each of the issues identified and the legislature's directions in SJR 32 and briefly describes the Subcommittee's or Council's recommendation to each issue and information compiled and reviewed.

The rising cost of liability insurance for health care providers

There is little doubt that MMLI premiums have increased in Montana in recent years, accelerating considerably in the last 2-3 years.¹¹¹ The factors affecting the cost of liability insurance are numerous, sometimes complex, often intertwined, and strenuously debated. Several of the cost factors get the bulk of attention, including tort laws affecting medical providers and malpractice claimants, declining competition due to fewer insurers or other factors, explosions in the number of medical malpractice claims and jury awards stemming from the claims, the cyclical nature of the insurance business, and declines in investment income. The Subcommittee reviewed each of these front page factors, as well as others.

¹¹¹ "Detail Business in the State" (1998-2003 series), State Insurance Commissioner, Helena, MT, and testimony to the SJR 32 Subcommittee.

Medical liability statutes

In the main, the legal environment surrounding and underpinning medical liability is often pointed to by insurers and their insureds as a cause of rising premiums. That theme was evident in the testimony from doctors across the state.¹¹² In Montana, recent Legislatures have significantly revised code provisions by enacting California's MICRA-type reforms to improve this state's legal environment. Because Montana's medical liability statutes have, since 1995, reflected nearly all of the provisions advocated by the liability insurance industry, state and national medical associations, doctors and others testifying before the Subcommittee, numerous radio and television talk show wags, and other tort reform advocates, it is debatable whether additional tort reforms can or will visibly affect MMLI premiums in Montana.

However, to the extent that the Legislative Council could, after reviewing, discussing, and debating the findings, conclusions, and recommendations of the Subcommittee, identify additional statutory reforms to further improve the medical liability environment in Montana, the members examined and reviewed several options and recommend LCs 5001, 5004, 5005, and 5007. (See Appendix A.)

Declining competition from fewer providers

Competition among MMLI providers in Montana may have declined for a number of reasons, but competition cannot have faded as the result of a decrease in the raw numbers of insurers licensed to sell MMLI or actually selling MMLI and collecting premiums. As illustrated in Chapter 3, the number of insurers licensed to sell and the number of insurers selling MMLI in Montana has remained essentially the same for at least the past 6

¹¹² See *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, November 16-17, 2003.

years.¹¹³ Because the current crisis first emerged only 3 years ago or less, fewer Montana insurers cannot be a reason for diminished competition.

Explosion in malpractice claims

Every claim of medical malpractice in Montana must, by statute, be reviewed by the Montana Medical Legal Panel. Therefore, records maintained by the Panel should be a definitive source of data regarding the number of claims filed. According to testimony from staff of the Panel,

...in an absolute sense, the rate of claims and the rate of cases filed are both diminishing in Montana. In 2000, Montana had a total of 93 paid claims, as reported by the National Practitioner Data Bank. In 2001, Montana had 67 paid claims and in 2002, Montana had 69 paid claims.¹¹⁴

The absolute number of claims filed annually has remained relatively stable since 1995 at about 175 claims per year.¹¹⁵ Whether computed on a per 1,000 physician basis or a per 1 million population basis, the trend of the rate of physicians involved in claims has been steadily decreasing in Montana for the past decade.¹¹⁶

At 19 per 1,000 doctors in active practice, Montana also compares favorably on a national basis in the number of lawsuits.¹¹⁷ Nationally, the average rate

¹¹³ Ibid.

¹¹⁴ Taken from the *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, Nov. 17, 2004, pp. 13-16.

¹¹⁵ Table showing "Montana Physicians Involved in Medical Malpractice Claims" in *2004 Annual Report of the Montana Medical Legal Panel*, p. 10. The fewest claims was 158 (1999), the most was 203 in 1995.

¹¹⁶ *2004 Annual Report of the Montana Medical Legal Panel*, p. 10.

¹¹⁷ Table showing "Medical Liability Lawsuits Against Physicians-Number Of Lawsuits Per 1,000 Physicians" in *2004 Annual Report of the Montana Medical Legal Panel*, p. 16.

is about 145 lawsuits per 1,000 doctors.¹¹⁸ Of the 18 states for which data was reported, Montana ranked lower in lawsuits per 1,000 than all but Connecticut (16/1000) and Minnesota (10/1000).¹¹⁹

Finally, at meeting after meeting of the Subcommittee, doctors repeatedly and uniformly testified that they, personally, had not had a medical malpractice claim filed recently (within 10 years), if ever.

From the information provided to the Subcommittee and the Council, it was fairly clear that *Montana has not seen an explosion* in the nominal number of claims and, in fact, *has experienced a decline* in the relative number of claims in recent years.

Explosion in jury awards

With respect to changes in the severity of jury awards in Montana, it is very difficult to reach any objective conclusion. Nominal amounts awarded by juries are increasing, and logically they should be, particularly because the bulk of jury awards in Montana are for actual damages that include primarily lost wages and future medical expenses.¹²⁰ Therefore, without knowing the specifics of each case and the nature and scope of each award, including the factors considered in making the award, just comparing jury awards would be merely academic and could lead to spurious or erroneous conclusions. Concluding that awards have "exploded" without considerable, detailed documentation would be, at best, inadvisable.

¹¹⁸ Ibid.

¹¹⁹ Ibid.

¹²⁰ The literature and testimony both gave examples of injuries that would have been fatal not long ago but from which the victim might these days be saved, only to face expensive therapy and rehabilitation for years to come or succumb to decades of life in a nursing home.

To their credit, insurers provided the Subcommittee and, indirectly, the Council with selected financial data showing paid losses, incurred losses, earned premiums, direct premiums earned, net premiums earned, and loss ratios, among other information.

But insurers have income in addition to earned premiums and they incur expenses other than direct losses, particularly direct losses from jury awards. Settlement amounts, actual versus noneconomic losses, income from sources other than direct premiums earned, changes in expenses other than direct losses, experience and expectations regarding changes in medical costs and wages, and other data are clearly necessary if the whole picture is to be seen and appreciated. Therefore, a conclusion regarding exploding severity is elusive and perhaps unknowable at this time because of the lack of useful, readily available data.

Nevertheless, the Subcommittee heard testimony that jury awards and, by implication or assertion, courts were getting out of control. A representative of The Doctors Company (TDC) testified,

In the years immediately following the enactment of Montana medical tort reform statutes [1995], we observed a notable decline in Montana claims severity, but this picture has, unfortunately, reversed. While difficult to pinpoint, we attribute the sharp rise in claims costs to medical cost inflation, increasingly liberal court awards, and societal norms relating to litigiousness and entitlement.¹²¹

Similarly, a representative of the Utah Medical Insurance Association (UMIA) testified that premiums for Montana's doctors and hospitals were likely to

¹²¹ Testimony of Richard E. Anderson, MD, Chairman, The Doctors Company, in *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, January 15, 2004, Exhibit #4, p. 5.

continue to increase "without changes in the case law."¹²² The implication was clearly that the severity of damages awarded through litigation had been increasing and, absent changes, UMIA anticipated further increases. Unfortunately, neither the UMIA nor TDC presented detailed documentation specific to jury awards.

The insurance cycle

The Subcommittee received information and testimony, provided to the Legislative Council as well, that at least part of the increase in MMLI premiums is likely due to the cyclical nature of the MMLI business. For example,

Insurers make most of their profits from investment income. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premium dollars to invest for maximum return. Insurers severely underprice their policies and insure very poor risks just to get premium dollars to invest. This is known as the "soft" insurance market. But when investment income decreases — because interest rates drop or the stock market plummets or the cumulative price cuts make profits become unbearably low—the industry responds by sharply increasing premiums and reducing coverage, creating a "hard" insurance market.... A hard insurance market happened in the mid-1970s, precipitating rate hikes and coverage cutbacks, particularly with medical malpractice insurance and product liability insurance. A more severe crisis took place in the mid-1980s, when most liability insurance was impacted. Again, in 2002, the country experienced a "hard market," this time impacting property as well as liability coverages with some lines of insurance seeing rates going up 100% or more.¹²³

Information provided by TDC and UMIA confirmed that description and showed that both companies were loath to increase rates during the 1990s.

¹²² Testimony of Martin Oslowski, Utah Medical Insurance Association, in *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, January 15, 2004, p. 12.

¹²³ *Op. cit.*, Medical Malpractice Insurance: Stable Losses/Unstable Rates 2003, p. 4.

Their reluctance reversed, however, quickly and drastically in conjunction with and following the declines in the financial markets beginning in 2000.¹²⁴ Whether the reversal was a matter of coincidence with the reversal in the financial markets' health is strenuously advocated (e.g., by various insurers and some tort reform advocates) and equally strenuously challenged (e.g., by various consumer advocates and some trial lawyers).

Declining investment income

As with several of the other issues, there is considerable disagreement about the effect of declining investment income. Insurance reform advocates point to the bursting of the "tech bubble" in early 2000 as coinciding with the emergence of the current insurance crisis. Insurance reform opponents shun that argument, declaring and documenting that liability insurers have the bulk of investable assets squirreled away in cash, money market funds, and high quality bonds. No less of an authority that the U.S. General Accounting Office concluded:

Insurers' losses, declines in investment income, a less competitive climate, and climbing reinsurance rates have all contributed to rising premium rates. First, among our seven sample states, insurers' losses have increased rapidly in some states, increasing the amount that insurers expect to pay out on future claims. Second, on the national level insurers' investment income has decreased, so that insurance companies must increasingly rely on premiums to cover costs. Third, some large medical malpractice insurers have left the market in some states because selling policies was no longer profitable, reducing the downward competitive pressure on premium rates that existed through most of the 1990s. Last, reinsurance rates for some medical malpractice insurers in our seven sample states have increased substantially, increasing insurers' overall costs. In

¹²⁴ "Detail Business in the State" (1998-2003 series) , State Insurance Commissioner, Helena, MT, and testimony of Martin Osowski, Utah Medical Insurance Association, in *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, January 15, 2004.

combination, all the factors affecting premium rates and the availability of medical malpractice insurance contribute to the medical malpractice insurance cycle of hard and soft markets.¹²⁵

In the final analysis, one could conclude that declining investment income was and continues to be a contributing and, perhaps, significant factor to increasing MMLI premiums. Unfortunately, there is little if anything that state policymakers might do to change that fact.

Linking rising MMLI premiums and rising costs of medical care

This is another case of "absolutely contradictory information by both sides, [where] sorting out the reality and fact is difficult"¹²⁶—at least without looking beyond mere statements of fact. For example, the American Medical Association states that medical liability costs add \$60 billion to \$108 billion to the costs of health care each year.¹²⁷ In the words of the late Senator Everett Dirksen, that's talking "real money".

By contrast, the group Americans for Insurance Reform states:

Medical malpractice payouts are less than one percent of total U.S. health care costs. All "losses" (verdicts, settlements, legal fees, etc.) have stayed under 1% for the last 18 years. In 2002, payouts were less than one percent (0.38%). Medical malpractice premiums are less than one percent of total U.S. health care costs. Dropping for nearly two

¹²⁵ *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, U.S. General Accounting Office, June 2003, (GAO-03-702), p 15.

¹²⁶ Telephone conversation with John Miller, Staff, California Senate Office of Research, September 2003.

¹²⁷ "Medical Liability Talking Points", American Medical Association, March 2004, on the Internet at URL http://www.ama-assn.org/ama1/pub/upload/mon/399/mlr_tp.pdf. The figures are attributed in the document to "U.S. Department of Health and Human Services, July 2002."

decades, malpractice premiums have stayed below 1% of health care costs. In 2002, premiums were less than one percent (0.58%).¹²⁸

For starters, let us trust that the statements of both the Americans for Insurance Reform and the AMA are truthful.

Accepting the AMA figures at face value, each Montanan in 1998 sustained from \$204 to \$267 annually in medical liability costs¹²⁹ and the state as a whole carried somewhere between \$185 million and \$334 million in medical liability costs.¹³⁰ Those amounts can be translated into 6.4% to 11.5% of the total expenditures for health care in Montana.¹³¹ According to 2002 figures captured by the State Insurance Commissioner, aggregate MMLI premiums of \$22.9 million plus all incurred losses of \$34.6 million totaled about \$57.5 million. Therefore, the \$130 million to \$200 million in medical liability costs unaccounted for must be hidden costs.

Accepting the Americans for Insurance Reform figures in the same vein as the AMA's figures, insurance premiums in Montana for 1998 should have been approximately \$16.24 million (0.58% x \$2.918 billion¹³²), and were

¹²⁸ "Think Malpractice is Driving Up Health Care Costs? Think Again.", undated, online at Americans for Insurance Reform, URL <http://www.insurance-reform.org/>.

¹²⁹ Staff estimate by dividing the total medical liability costs of \$60-\$108 billion by 294 million people, the U.S. population from the 2000 Census.

¹³⁰ The per-Montanan cost, low and high, multiplied by 910,000 Montanans.

¹³¹ Figures for total health care expenditures for Montana, \$2,918,000,000, are from State Health Facts Online at the Kaiser Family Foundation website, URL <http://www.statehealthfacts.org/>.

¹³² State Health Facts Online at the Kaiser Family Foundation website, URL <http://www.statehealthfacts.org/>.

about \$16.5 million,¹³³ and all "losses" should have been about \$11.1 million ($0.38\% \times \$2.918$ billion), but were actually closer to \$16.1 million.¹³⁴ By these calculations and Americans for Insurance Reform figures, MMLI as a business should have netted about \$5.1 million in Montana in 1998, but reported an excess of premiums over losses of only about \$0.4 million.

What we *know* from published data is that MMLI premiums in 1998 were about \$16.5 million.¹³⁵ We also know that total health care expenditures in Montana in 1998 were about \$2.92 billion. The total 1998 premiums divided by total 1998 personal health care expenditures is approximately 0.57%. The aggregated premiums *plus* incurred losses totaled about \$32.6 million, approximately 1.1% of total health care expenditures in 1998.

We also *know* that MMLI premiums in 2002 were about \$22.89 million and total incurred losses were approximately \$34.6 million (or 0.86% of total health care costs).¹³⁶ Totaled, premiums plus losses for 2002 were about \$57.5 million (or 1.42% of total health care costs).

From information presented previously,¹³⁷ medical inflation averaged about 6.7% between 1990 and 2001. Applying that growth rate to the 1998 figure of \$2.92 billion for total health care expenses, a reasonable estimate of the same expenditures in 2003 could be \$4.03 billion. That suggests an increase

¹³³ "1998 Detail Business in the State", State Insurance Commissioner, Helena, MT Office of the Insurance Commissioner reports.

¹³⁴ *Ibid.*

¹³⁵ "2002 Detail Business in the State: Medical Malpractice", State Insurance Commissioner, Helena, MT.

¹³⁶ "2002 Detail Business in the State: Medical Malpractice", State Insurance Commissioner, Helena, MT.

¹³⁷ "Commentary: A Second Opinion on the Malpractice Plague", by Lorraine Woellert, *BusinessWeek online*, March 3, 2003.

in total expenditures for medical care in Montana from 1998 to 2003 of about \$1.1 billion. On a percentage basis, aggregated premiums plus incurred losses as a proportion of total health care expenditures may have grown to about 1.42%. That compares to 1.1% in 1998, an increase of 0.31% over the 5 years or about 0.06% annually.

The short of it is that total health care expenditures in Montana may have grown from about \$2.92 billion only 6 years ago to about \$4.03 billion last year, an increase of more or less \$1.12 billion. The increase in Montana MMLI premiums over the same time period is about \$9.8 million. The difference between the increase in total health care expenditures and the increase in total MMLI premiums is about \$1.1 billion. Of that increase, MMLI premium growth accounted for 0.88% of the growth, less than 1 penny for each dollar spent on health care.

Based on these figures, it is difficult to conclude that increases in MMLI premiums have had any discernable effect on the escalating costs of medical care. As a corollary, it is also difficult to support the premise that stabilizing MMLI premiums could contribute in any meaningful way toward cost containment for health care for Montana citizens.

The effects of MMLI premiums on medical practice

The literature is full of anecdotes about doctors moving their practices from one state to another, about other doctors retiring early, about doctors practicing defensive medicine, and about communities in which there is no longer a doctor who will deliver babies, but perhaps several who used to.

Testimony given to the Subcommittee repeated many of the same warnings: disappearing access; practices and doctors moving across state lines; early

retirements; and so on.¹³⁸ There was no indication given by any of the witnesses that the warnings were not legitimate or the effects of the actions imminent.

However, there have also been investigations to determine the accuracy of similar stories in other jurisdictions, some of which have found little supporting evidence. Again relying on the GAO:

... we also determined that many of the reported provider actions taken in response to malpractice pressures were not substantiated or did not widely affect access to health care. For example, some reports of physicians relocating to other states, retiring, or closing practices were not accurate or involved relatively few physicians. In these same states, our review of Medicare claims data did not identify any major reductions in the utilization of certain services some physicians reported reducing because they consider the services to be high risk, such as certain orthopedic surgeries and mammograms.¹³⁹

The possibility that doctors will reduce services, move their practices, retire, or take some other action on the basis of increasing MMLI premiums must be viewed as real. The ability of policymakers to affect any such choice is much less clear.

Strategies to increase the availability of affordable liability insurance

The Subcommittee worked painstakingly at identifying avenues to increase the availability and affordability of MMLI. Subsequently, the Legislative Council worked to separate the Subcommittee's recommendations into those more likely to achieve the objectives of SJR 32 from those less likely to do

¹³⁸ *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, November 16-17, 2003, *et. seq.*

¹³⁹ *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, U.S. General Accounting Office, August 2003 (GAO-03-836), p. 5.

so. Most of Chapter 4 discusses some of the options considered. In the end, the Subcommittee recommended to the Council six bills—LCs 5001, 5002, 5004, 5005, 5007, and 5008—to further reform Montana's medical liability laws, i.e., tort reform, and two other bills—LCs 5000 and 5009—to establish or allow alternative insurance products.

Exercising its own collective best judgment, the Legislative Council recommends to the 59th Legislature four bills—LCs 5001, 5004, 5005, and 5007.

It is the hope and belief of the Legislative Council that in combination or individually the recommended bills will help to alleviate the perceived unavailability of MMLI in Montana or mitigate the recent rates of increase in MMLI premiums, or both.

Resolving liability claims outside of courts

Montana has had the Montana Medical Legal Panel for over 25 years. Testimony given to the Subcommittee by both trial lawyers and defense attorneys uniformly praised the objectives, the functioning, and the outcomes of the Panel. It is viewed by legal practitioners as a bona fide success.

In contrast, many doctors testified that the Panel is an exercise in the infliction of anxiety. Some recounted unbearable stresses associated with the Panels, others complained that a Panel vote favoring the doctor was rarely heeded by the claimant. Still others viewed the Panels as little more than a thinly veiled opportunity for trial lawyers to preview the strength of the doctor's evidence or defense strategy.

In the end, the Subcommittee agreed that Panels effectively serve the purposes for which they were created—a screening tool to weed out

frivolous claims; a venue for claimants and defendants alike to receive an objective assessment of the claim; an opportunity for a claimant to confront the individual(s) whom the claimant believes did him or her harm—and chose not to recommend revising the Panels. Likewise, the Legislative Council does not propose revising the Panels.

The Subcommittee also considered other, nonjudicial alternatives, including voluntary and mandatory arbitration, both binding and nonbinding. In light of the perceived success of the Montana Medical Legal Panel, however, the Subcommittee initially, and the Legislative Council ultimately, did not pursue arbitration.

One element that did catch both the Subcommittee's and the Council's attention was a proposal to allow a doctor or other medical provider to face a claimant and offer an act of or words of benevolence and protect the medical provider from the act or statement from being used as evidence in a civil action for medical malpractice.

Testimony revealed that some medical providers, both individuals and institutions, often desire to express an apology, fault, sympathy, compassion, etc., for the pain, suffering, or death of a person in their care. However, in such instances health care providers are typically advised by legal counsel to refrain from such expressions for fear that the expression will be proffered as evidence of an admission of liability.

Recognizing a potentially perverse consequence from a sincere act of grace and an opportunity to eliminate the potential, the Subcommittee recommended LC 5007 and the Legislative Council does as well.¹⁴⁰

Summary and conclusion

For the better part of a year, the members of the SJR 32 Subcommittee on Medical Liability Insurance diligently studied the many facets of medical liability insurance. They read countless pages of reports, articles, essays, opinions, audits, bills, program designs, tables and graphs, and similar documents. They listened to hours of presentations and testimony, some face to face, other through video conferencing technology. They learned of the history of liability or tort reforms, particularly in Montana, and the status of Montana's laws and legal precedents as developed in recent years.

Ultimately, they engaged in discussions about the causes of medical liability insurance problems—rapidly increasing premiums and declining availability—and about policy options designed to address the causes and thereby alleviate the problems. They considered more than 60 ideas, requested that draft legislation be prepared to encompass 10 of those ideas, and recommended eight of the ideas proposed as the draft bills contained in Appendices A and B.

Having dutifully fulfilled the charge given to them by the Legislative Council, the Subcommittee respectfully submitted its final report and recommended the draft legislation contained in Appendices A and B.

¹⁴⁰ The Subcommittee also concluded that an act of benevolence as characterized in LC 5007 might be sufficient to satisfy the needs of a claimant and, thus, saw the bill as an opportunity to further reduce litigation.

Similarly, the Legislative Council completes the Legislature's assignment under SJR 32 by submitting this report and recommending LCs 5001, 5004, 5005, and 5007, as contained in Appendix A.

Appendix A

Recommended Draft Legislation: By the Legislative Council to the 59th Legislature

Pursuant to Senate Joint Resolution No. 32, the following draft bills are recommended to the 59th Legislature by the Legislative Council:

LC 5001

LC 5004

LC 5005

LC 5007

Each these four draft bills, in addition to the four drafts contained in Appendix B, were recommended to the Legislative Council by its SJR 32 Subcommittee on Medical Liability Insurance. However, the Legislative Council recommends to the 59th Legislature only the four bills contained in this appendix.

____ BILL NO. ____

INTRODUCED BY _____
(Primary Sponsor)

BY REQUEST OF THE LEGISLATIVE COUNCIL

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING THAT FOR PURPOSES OF A MEDICAL MALPRACTICE CLAIM, LIABILITY MAY NOT BE IMPOSED ON A HEALTH CARE PROVIDER FOR AN ACT OR OMISSION BY A PERSON OR ENTITY ALLEGED TO HAVE BEEN AN OSTENSIBLE AGENT OF THE HEALTH CARE PROVIDER AT THE TIME THAT THE ACT OR OMISSION OCCURRED; AMENDING SECTION 28-10-103, MCA; AND PROVIDING AN APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 28-10-103, MCA, is amended to read:

"28-10-103. Actual versus ostensible agency -- limitation. (1) An agency is either actual or ostensible. An agency is actual when the agent is really employed by the principal. An agency is ostensible when the principal intentionally or by want of ordinary care causes a third person to believe another to be his the principal's agent ~~who~~ when that person is not really employed by ~~him~~ the principal.

(2) For purposes of a malpractice claim, as defined in 27-6-103, liability may not be imposed on a health care provider, as defined in 27-6-103, for an act or omission by a person or entity alleged to have been an ostensible agent of the health care provider at the time that the act or omission occurred."

NEW SECTION. **Section 2. Applicability.** [This act] applies to malpractice claims that arise after [the effective date of this act].

- END -

____ BILL NO. ____

INTRODUCED BY _____
(Primary Sponsor)

BY REQUEST OF THE LEGISLATIVE COUNCIL

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING THAT FOR PURPOSES OF A MALPRACTICE CLAIM, A HEALTH CARE PROVIDER IS NOT LIABLE FOR AN ACT OR OMISSION BY A PERSON OR ENTITY THAT WAS NOT AN EMPLOYEE OR AGENT OF OR OTHERWISE UNDER THE CONTROL OF THE HEALTH CARE PROVIDER AT THE TIME THAT THE ACT OR OMISSION OCCURRED; AND PROVIDING AN APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. Section 1. Health care provider's responsibility for others.

For purposes of a malpractice claim, as defined in 27-6-103, a health care provider, as defined in 27-6-103, is not liable for an act or omission by a person or entity that was not an employee or agent of or otherwise under the control of the health care provider at the time that the act or omission occurred. This section does not absolve a health care provider from liability under 27-1-703.

NEW SECTION. Section 2. Codification instruction. [Section 1] is intended to be codified as an integral part of Title 27, chapter 1, part 7, and the provisions of Title 27 apply to [section 1].

NEW SECTION. Section 3. Applicability. [This act] applies to malpractice claims that arise after [the effective date of this act].

- END -

_____ BILL NO. _____

INTRODUCED BY _____
(Primary Sponsor)

BY REQUEST OF THE LEGISLATIVE COUNCIL

A BILL FOR AN ACT ENTITLED: "AN ACT REGULATING DAMAGES THAT MAY BE GRANTED FOR MEDICAL MALPRACTICE THAT REDUCES A PATIENT'S CHANCE OF RECOVERY; AND PROVIDING AN APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. Section 1. Liability of health care provider for reduced chance of recovery caused by malpractice. (1) For purposes of a malpractice claim, as defined in 27-6-103, damages may be awarded against a health care provider, as defined in 27-6-103, if a negligent act or omission during diagnosis or treatment for a medical condition reduces a patient's chance of recovering and the negligent act or omission is a contributing cause of:

- (a) death;
- (b) survival for a shorter period of time;
- (c) no recovery;
- (d) a recovery that is of lesser extent or quality or that takes longer to occur; or
- (e) other injury.

(2) The damages must be determined based on which of the events referred to in subsections (1)(a) through (1)(e) occurred and the resulting types of injury, damage, and loss.

(3) Damages awarded must be the difference between the percentage chance of recovering prior to the negligent act or omission and the percentage chance of recovering after the negligent act or omission, multiplied by the total damages proved under subsection (2).

NEW SECTION. **Section 2. Applicability.** [This act] applies to malpractice claims that arise after [the effective date of this act].

- END -

____ BILL NO. ____

INTRODUCED BY _____
(Primary Sponsor)

BY REQUEST OF THE LEGISLATIVE COUNCIL

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING THAT A STATEMENT, AFFIRMATION, GESTURE, OR CONDUCT EXPRESSING APOLOGY, FAULT, SYMPATHY, COMMISERATION, CONDOLENCE, COMPASSION, OR BENEVOLENCE RELATING TO THE PAIN, SUFFERING, OR DEATH OF A PERSON THAT IS MADE TO THE PERSON, THE PERSON'S FAMILY, OR A FRIEND OF THE PERSON OR OF THE PERSON'S FAMILY IS INADMISSIBLE AS EVIDENCE OF AN ADMISSION OF LIABILITY IN A CIVIL ACTION FOR MEDICAL MALPRACTICE; AND PROVIDING AN APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. Section 1. Statement of apology, sympathy, or benevolence -- not admissible as evidence of admission of liability for medical malpractice.

(1) A statement, affirmation, gesture, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence relating to the pain, suffering, or death of a person that is made to the person, the person's family, or a friend of the person or of the person's family is not admissible as evidence of an admission of liability in a civil action for medical malpractice.

(2) As used in this section, the following definitions apply:

(a) "Apology" means a communication that expresses regret or asks for a pardon for a fault or offense.

(b) "Benevolence" means a communication that conveys a sense of compassion or commiseration emanating from humane impulses.

(c) "Communication" means a statement, writing, or gesture.

(d) "Family" means the spouse, parent, spouse's parent, grandparent, stepmother, stepfather, child, grandchild, sibling, half-sibling, or adopted children of a parent of an injured party.

NEW SECTION. **Section 2. Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 26, chapter 1, and the provisions of Title 26, chapter 1, apply to [section 1].

NEW SECTION. **Section 3. Applicability.** [This act] applies to causes of action arising after [the effective date of this act].

- END -

Appendix B

Other Draft Legislation: By the SJR 32 Subcommittee on Medical Liability Insurance to the Legislative Council

Recommended to the Legislative Council by the SJR 32 Subcommittee on Medical Liability Insurance:

LC 5000

LC 5002

LC 5006

LC 5008

These four draft bills, in addition to the four drafts contained in Appendix A, were recommended to the Legislative Council by the Subcommittee. However, the Legislative Council did not vote to recommend to the 59th Legislature any of the four contained in this appendix.

**** Bill No. ****

Introduced By *****

By Request of the *****

1 A Bill for an Act entitled: "An Act creating the Health Care
2 Liability and Injured Patients Compensation Act; requiring
3 the insurance commissioner to establish a health care
4 liability insurance plan; requiring certain health care
5 providers to participate in the health care liability
6 insurance plan; allowing certain health care providers to
7 participate in the health care liability insurance plan;
8 exempting certain health care providers from participation in
9 the health care liability insurance plan; providing for the
10 administration of the health care liability insurance plan;
11 making certain health care providers and certain persons
12 alleging medical negligence subject to the provisions of the
13 Health Care Liability and Injured Patients Compensation Act;
14 limiting noneconomic damages for medical negligence;
15 establishing a health care liability insurance plan board of
16 governors and describing the authority, duties, and
17 responsibilities of the board; establishing an injured
18 patients and families compensation fund and providing for the
19 administration of the fund, including setting and collecting
20 premiums to establish and sustain the fund; establishing an
21 injured patients and families compensation fund peer review
22 council and describing the authority, duties, and
23 responsibilities of the council; revising the composition of
24 the board of medical examiners to include the presiding
25 officer of the injured patients and families compensation

1 fund peer review council; requiring the board of investments
2 to invest the assets of the injured patients and families
3 compensation fund; revising certain provisions regarding the
4 Montana Medical Legal Panel; revising the authority, duties,
5 and responsibilities of the insurance commissioner in order
6 to administer certain provisions of the Health Care Liability
7 and Injured Patients Compensation Act; amending sections 2-
8 15-1731, 17-6-201, 17-6-203, 25-9-402, 25-9-403, 25-9-412,
9 27-6-103, 27-6-105, 27-6-606, and 33-1-311, MCA; providing
10 for transition; and providing effective dates and an
11 applicability date."

12
13 Be it enacted by the Legislature of the State of Montana:

14
15 NEW SECTION. **Section 1. Short title.** [Sections 1
16 through 32] may be referred to as the Health Care Liability
17 and Injured Patients Compensation Act.

18
19 NEW SECTION. **Section 2. Definitions.** As used in
20 [sections 1 through 32], unless the meaning clearly requires
21 otherwise, the following definitions apply:

22 (1) "Adjacent state" means any of the following states:
23 Idaho, North Dakota, South Dakota, or Wyoming.

24 (2) "Advanced practice registered nurse" means an
25 advanced practice registered nurse licensed by the state of
26 Montana under Title 37, chapter 8, who is certified as a
27 advanced practice registered nurse by the state board of
28 nursing.

29 (3) "Board" means the board of governors created in

1 [section 21].

2 (4) "Claimant" means any patient who has a claim, the
3 patient's representative, or any spouse, parent, minor
4 sibling, or child of the patient who has a derivative claim
5 for injury or death due to medical negligence.

6 (5) "Commissioner" means the commissioner of insurance
7 provided for in 2-15-1903.

8 (6) "Council" means the injured patients and families
9 compensation fund peer review council established in [section
10 28].

11 (7) "Department" means the department of public health
12 and human services established in 2-15-2201.

13 (8) "Fiscal year" means the period beginning on July 1
14 and ending on the following June 30.

15 (9) "Fund" means the injured patients and families
16 compensation fund established in [section 19].

17 (10) "Health care facility" has the meaning provided in
18 50-5-101.

19 (11) "Health care professional" means an individual who
20 is licensed, registered, or certified pursuant to Title 37,
21 chapter 3, 4, 6, 8, 10 through 14, 17, or 20 through 28.

22 (12) "Health care provider" means a person:

23 (a) to whom [sections 1 through 32] apply under
24 [section 4(1)]; or

25 (b) who elects to be subject to [sections 1 through 32]
26 under [section 4(2)].

27 (13) "Medical negligence" means a negligent act or
28 omission of a health care provider acting within the scope of
29 the health care provider's employment or profession while

1 providing health care services.

2 (14) "Patient" means an individual who received or
3 should have received health care services from a health care
4 provider or from an employee of a health care provider acting
5 within the scope the employee's employment.

6 (15) "Physician" has the meaning provided in 37-3-102.

7 (16) "Plan" means the health care liability insurance
8 plan for health care providers established under [section 3].

9 (17) "Principal place of practice" means the state in
10 which a health care provider:

11 (a) furnishes health care services to more than 50% of
12 the health care provider's patients in a fiscal year; or

13 (b) derives more than 50% of the health care provider's
14 income in a fiscal year from the practice of the provider's
15 profession.

16 (18) "Representative" means the personal
17 representative, spouse, parent, guardian, or attorney or
18 other legal agent of a patient.

19
20 NEW SECTION. **Section 3. Health care liability**
21 **insurance plan.** (1) The commissioner shall promulgate rules
22 establishing a plan of health care liability coverage for
23 health care providers.

24 (2) The plan must:

25 (a) operate subject to the supervision and approval of
26 the board;

27 (b) offer professional health care liability coverage
28 in a standard policy form;

29 (c) include but not be limited to the following:

1 (i) rules for the classification of risks and rates
2 that reflect past and prospective loss and expense experience
3 in different areas of practice and of the fund; and

4 (ii) a rating plan that takes into consideration the
5 loss and expense experience of an individual health care
6 provider, which experience resulted in the payment of money,
7 by the plan or other sources, for damages arising out of
8 medical negligence, except that an adjustment to a health
9 care provider's premiums may not be made under this section
10 prior to the receipt of the recommendation of the council and
11 the expiration of the time period provided in [section 30(4)]
12 for the health care provider to comment, or prior to the
13 expiration of the time period provided in [section 30(1)];
14 and

15 (d) include provisions for setting rates for insureds
16 who are semiretired or who work only part-time.

17 (3)(a) The part of the plan described in subsection
18 (2)(c)(ii) must provide for an automatic increase in the
19 premium payable by a health care provider, except as provided
20 in subsection (3)(b), if the loss and expense experience of
21 the plan and other sources with respect to the health care
22 provider or an employee of the health care provider exceeds
23 either a number of claims paid threshold or a dollar volume
24 of claims paid threshold, each threshold as established in
25 the plan. The plan must also specify applicable amounts of
26 increase corresponding to the number of claims paid and the
27 dollar volume of awards in excess of the respective
28 thresholds.

29 (b) The plan must provide that the automatic increase

1 does not apply if the board determines that the performance
2 of the council in making recommendations under [section
3 30(2)] adequately addresses the consideration set forth in
4 subsection (2)(c)(ii).

5 (4)(a) The board shall annually determine if the plan
6 has accumulated funds in excess of the surplus required under
7 33-2-109.

8 (b) If the board determines that the fund has
9 accumulated funds in excess of the surplus required, the
10 board must:

11 (i) specify the method and formula for distributing the
12 excess funds; and

13 (ii) return the excess funds to the insureds by means
14 of refunds or prospective rate decreases.

15 (5) The state or the board may not be held liable for
16 any obligation of the plan or of the fund.

17 (6)(a) If the commissioner determines that a health care
18 provider is not subject to this section, the commissioner
19 may, with the approval of the board, promulgate rules
20 permitting the health care provider and all other similarly
21 situated health care providers to obtain coverage under the
22 plan.

23 (b) A health care provider that obtains coverage
24 pursuant to subsection (6)(a) is subject to the provisions of
25 [sections 1 through 32] in the same manner as a health care
26 provider that is specifically subject to [sections 1 through
27 32].

28 (7) If the plan established under this section is
29 dissolved for any reason, any assets of the plan that exceed

1 the incurred liabilities of the plan accrue to the state
2 general fund.

3
4 NEW SECTION. Section 4. Participation -- when required
5 -- optional. (1) Except as provided in [section 5],
6 [sections 1 through 32] apply to the following:

7 (a) a physician or an advanced practice registered
8 nurse for whom this state is a principal place of practice
9 and who practices the profession for which the physician or
10 nurse is licensed in this state for 240 hours or more in a
11 fiscal year;

12 (b) a physician or an advanced practice registered
13 nurse for whom an adjacent state is a principal place of
14 practice, if the physician or advanced practice registered
15 nurse:

16 (i) is a resident of this state;

17 (ii) practices the profession for which the physician
18 or nurse is licensed in this state or in an adjacent state or
19 a combination of this state and an adjacent state for 240
20 hours or more in a fiscal year; and

21 (iii) performs more procedures in an adjacent-state
22 health care facility than in any other health care facility;

23 (c) a physician or an advanced practice registered nurse
24 who is exempt under [section 5(1) or (3)] but who practices
25 the profession for which the physician or nurse is licensed
26 outside the scope of the exemption and who fulfills the
27 requirements under subsection (1)(a) in relation to that
28 practice outside the scope of the exemption. For a physician
29 or an advanced practice registered nurse who is, under this

1 section, subject to [sections 1 through 32], [sections 1
2 through 32] apply only to claims arising out of practice that
3 is outside the scope of the exemption under [section 5(1) or
4 (3)].

5 (d) a partnership comprised of physicians or advanced
6 practice registered nurses, or both, and organized and
7 operated in this state for the primary purpose of providing
8 the medical services of physicians or advanced practice
9 registered nurses;

10 (e) a corporation organized and operated in this state
11 for the primary purpose of providing the medical services of
12 physicians or advanced practice registered nurses, or both;

13 (f) a hospital facility, as defined in 7-34-2102, that
14 operates in this state;

15 (g) a health care facility that operates in this state;

16 (h) an entity operated in this state that is an
17 affiliate of a health care facility and that provides
18 diagnosis or treatment of or care for patients of the health
19 care facility; and

20 (i) a long-term care facility, as defined in 50-5-101,
21 whose operations are combined as a single entity with a
22 health care facility described in subsection (1)(g), whether
23 or not the operations of the long-term care facility are
24 physically separate from the health care facility operations.

25 (2) Any of the following may elect, in the manner
26 designated by the commissioner by rule, to be subject to
27 [sections 1 through 32]:

28 (a) a physician or an advanced practice registered
29 nurse:

1 (i) for whom this state is a principal place of
2 practice; and

3 (ii) who practices the profession for which the
4 physician or nurse is licensed for fewer than 240 hours in a
5 fiscal year or a portion of a fiscal year during which the
6 physician or advanced practice registered nurse practices the
7 profession for which the physician or nurse is licensed;

8 (b) except as provided in subsection (1)(b), a
9 physician or an advanced practice registered nurse for whom
10 this state is not a principal place of practice for a fiscal
11 year or a portion of a fiscal year during which the physician
12 or advanced practice registered nurse practices the
13 profession for which the physician or nurse is licensed in
14 this state.

15 (3) For a health care provider who elects, under this
16 section, to be subject to [sections 1 through 32], [sections
17 1 through 32] apply only to claims arising out of practice
18 that is in this state and that is outside the scope of an
19 exemption under [section 5(1) or (3)].

20

21 NEW SECTION. **Section 5. Exemptions.** Except as provided
22 in [section 4(1)(c)], [sections 1 through 32] do not apply to
23 a health care provider that is any of the following:

24 (1) a physician or an advanced practice registered
25 nurse who is:

26 (a) a state, county, or municipal employee; or

27 (b) a federal employee or a contractor covered under
28 the Federal Tort Claims Act and who is acting within the
29 scope of the employee's employment or contractual duties;

(2) a health care facility that is operated by any governmental agency; or

(3) a physician or an advanced practice registered nurse who provides, on a voluntary basis, professional services for which the physician or nurse is licensed and:

(a) with respect to only those professional services provided by the physician or advanced practice registered nurse for which the physician or advanced practice registered nurse is covered under Title 2, chapter 9; and

(b) for which the physician or advanced practice registered nurse is acting as an agent of the department.

NEW SECTION. **Section 6. Applicability to claimants.**

(1) For injury or death that is due to medical negligence, the following individuals are subject to [sections 1 through 32]:

(a) a patient who has a claim or the patient's representative; or

(b) a spouse, parent, minor sibling, or child of the patient who has a claim or a derivative claim.

(2) Any claimant asserting medical negligence against a health care provider or an employee of the health care provider is subject to [sections 1 through 32].

(3) The fund provides coverage for claims for medical negligence against the health care provider or the employee of the health care provider. However, this subsection does not apply to any of the following:

(a) an employee of a health care provider if the employee is a physician, an advanced practice registered

1 nurse, or a direct-entry midwife, as defined in 37-27-103,
2 who is providing direct-entry midwifery services that are not
3 in collaboration with a physician or under the direction and
4 supervision of a physician or an advanced practice registered
5 nurse;

6 (b) a professional service corporation organized under
7 Title 35, chapter 4, by health care professionals if the
8 board determines that providing the medical services of
9 physicians or advanced practice registered nurses is not the
10 primary purpose of the professional service corporation. The
11 board may not determine under this subsection (3)(b) that the
12 primary purpose of a professional service corporation is not
13 to provide the medical services of physicians or advanced
14 practice registered nurses unless more than 50% of the
15 shareholders of the service corporation are not physicians or
16 advanced practice registered nurses.

17 (4) Subsection (3) does not affect the liability of a
18 health care provider described in [section 4(1)(d), (1)(e),
19 or (1)(f)] for the acts of its employees.
20

21 NEW SECTION. **Section 7. Remedy limited.** [Sections 1
22 through 32] do not apply to injury or death:

23 (1) occurring from medical negligence or services
24 rendered prior to [the applicability date of this section];
25 or

26 (2) caused by a crime intentionally committed by a
27 health care provider or an employee of a health care
28 provider, whether or not the criminal conduct is the basis
29 for a medical negligence claim.

1
2 NEW SECTION. **Section 8. Claim by minor sibling.**

3 Subject to [section 13], a sibling of a person who dies as a
4 result of medical negligence has a cause of action for
5 damages for loss of society and companionship if the sibling
6 was a minor at the time of the deceased sibling's death. This
7 section does not affect any other claim available under
8 [sections 1 through 32].
9

10 NEW SECTION. **Section 9. Action to recover damages.** An
11 action to recover damages for medical negligence must comply
12 with the following:

13 (1) the complaint in an action regarding medical
14 negligence may not specify the amount of money to which the
15 plaintiff supposes to be entitled;

16 (2) the court or jury, whichever is applicable, shall
17 determine the amounts of medical expense payments previously
18 incurred and for future medical expense payments; and

19 (3) venue in a court action under [sections 1 through
20 32] is:

21 (a) if the claimant is a resident of this state, in the
22 county in which the claimant resides; or

23 (b) if the claimant is not a resident of this state, in
24 the county, at the claimant's discretion:

25 (i) in which the claim arose; or

26 (ii) in which the defendant resides in this state or
27 does the majority of the defendant's business in this state.
28

29 NEW SECTION. **Section 10. Forms.** Except as otherwise

specifically provided for in [sections 1 through 32], the commissioner shall prepare, have printed if necessary, and furnish, upon request, the forms and material the commissioner considers to be necessary to promote the efficient administration of [sections 1 through 32]. In satisfaction of this section, the commissioner may make available by electronic means the forms and material required under this section.

NEW SECTION. **Section 11. Limitation of attorney fees.**

(1) Except as provided in subsections (2) and (3), with respect to any act of medical negligence for which a contingency fee arrangement is entered into on or after [the applicability date of this section], in addition to compensation for the reasonable costs of prosecution of the claim, the compensation determined on a contingency basis and payable to all attorneys acting for one or more plaintiffs or claimants is subject to the following limitations:

(a)(i) 25% of the first \$1 million recovered if liability is stipulated within fewer than 180 days after the date of filing of the original complaint and more than 60 days before the first day of trial; or

(ii) 33 1/3% of the first \$1 million recovered if liability is not stipulated within 180 days or fewer after the date of filing of the original complaint and at least 60 days before the first day of trial; and

(b) 20% of any amount in excess of \$1 million recovered, regardless of the date of stipulation, settlement, verdict, or any other circumstance.

1 (2) A court may approve attorney fees in excess of the
2 limitations under subsection (1) upon a showing of
3 exceptional circumstances, including an appeal.

4 (3) An attorney shall offer to charge a client in a
5 medical negligence proceeding or action on a per diem or per
6 hour basis. An agreement for charges on a per diem or per
7 hour basis must be made in writing at the time of the
8 employment of the attorney. An attorney's fee on a per diem
9 or per hour basis is not subject to the limitations under
10 subsection (1).

11
12 NEW SECTION. **Section 12. Payment for future medical**
13 **expenses.** (1) If a settlement, award, or judgment under
14 [sections 1 through 32] resulting from medical negligence
15 that occurred on or after [the applicability date of this
16 section] provides for future medical expense payments in
17 excess of \$100,000, that portion of future medical expense
18 payments in excess of an amount equal to \$100,000, plus an
19 amount sufficient to pay the costs of collection, including
20 attorney fees reduced to present value, attributable to the
21 future medical expense payments must be paid into the fund.

22 (2) The commissioner shall, by rule:

23 (a) specify the criteria to be used to determine the
24 medical expenses related to the settlement or judgment,
25 taking into consideration developments in the provision of
26 health care; and

27 (b) develop a system for managing and disbursing the
28 money deposited under subsection (1) through payments for the
29 expenses, including a provision for the creation of a

1 separate account within the fund for each claimant's payments
2 and for crediting each claimant's account with a
3 proportionate share of any interest or other income earned by
4 the fund, based on that account's proportionate share of the
5 fund.

6 (3) The payments made under this section continue until
7 the account is exhausted or the patient dies, whichever
8 occurs first.

9
10 NEW SECTION. **Section 13. Limits on noneconomic**
11 **damages.** The amount of noneconomic damages recoverable by a
12 claimant or plaintiff under [sections 1 through 32] for
13 medical negligence, if the medical negligence occurred on or
14 after October 1, 1995, is subject to the limits established
15 in 25-9-411.

16
17 NEW SECTION. **Section 14. Information needed to set**
18 **premiums, assessments, or fees.** Upon request by the
19 commissioner, all information on health care facility bed
20 capacity, occupancy rates, and other information determined
21 by the commissioner to be necessary to set premiums,
22 assessments, or fees under [sections 1 through 32] must be
23 submitted by:

- 24 (1) the department;
25 (2) the Montana medical legal panel established in 27-
26 6-104; or
27 (3) any other entity determined by the commissioner to
28 have necessary information.
29

NEW SECTION. Section 15. Insurance policy forms. (1)

An insurer may not enter into or issue any policy of health care liability insurance until the insurer's policy form has been submitted to and approved by the commissioner as provided in Title 33, chapter 1, part 5.

(2) The filing of a policy form by any insurer with the commissioner for approval constitutes, on the part of the insurer, a conclusive and unqualified acceptance of all provisions of [sections 1 through 32] and an agreement by the insurer to be bound by [sections 1 through 32] as to any policy issued by the insurer to any health care provider.

(3) Notwithstanding subsections (1) and (2), the issuance of a policy of health care liability insurance by an insurer to a health care provider constitutes, on the part of the insurer, a conclusive and unqualified acceptance of all of the provisions of [sections 1 through 32] and an agreement by the insurer to be bound under the provisions of [sections 1 through 32] as to any policy issued by the insurer to a health care provider.

(4) A policy issued under [sections 1 through 32] must provide all of the following:

(a) that the insurer agrees to pay in full all of the following:

(i) attorney fees and other costs incurred in the settlement or defense of a claim;

(ii) any settlement, arbitration award, or judgment imposed against the insured under [sections 1 through 32] up to \$500,000 or the maximum liability limit for which the health care provider is insured, whichever is greater; and

1 (iii) any portion or all of the interest, as determined
2 by the board, on an amount recovered against the insured
3 under [sections 1 through 32] for which the insured is
4 liable; and

5 (b) that any termination of the policy by cancellation
6 or nonrenewal is not effective as to a patient claiming
7 medical negligence against the health care provider covered
8 by the policy unless the insured has been notified as
9 provided in subsection (5) and Title 33, chapter 15, part 11,
10 except that an insurer may cancel a health care provider's
11 policy under 33-15-1103 if the health care provider is no
12 longer licensed to practice the profession or provide the
13 medical services for which the health care provider is
14 licensed.

15 (5) A notice of cancellation or nonrenewal that is
16 required under subsection (4)(b) issued to a health care
17 provider who is a natural person must inform the person that
18 the person's license to practice the medical profession for
19 which the person is licensed may be suspended or not renewed
20 if the person does not have sufficient liability insurance.
21 The insurer shall retain a copy of each notice issued under
22 subsection (4)(b) for not less than 10 years from the date of
23 mailing or delivery of the notice and provide a copy to the
24 commissioner upon request.

25 (6) The insurer shall, upon termination of a policy of
26 health care liability insurance issued under [sections 1
27 through 32] by cancellation or nonrenewal, notify the
28 commissioner of the termination.
29

NEW SECTION. Section 16. Insurance policy limitations.

(1) A health care liability insurance policy may not allow a health care provider to reject a settlement agreed upon between the claimant and the insurer.

(2) A health care liability insurance policy may allow the insurer to make payments for medical expenses prior to any determination of fault. A payment made under this section:

(a) is not an admission of fault;

(b) may be deducted from a judgment or arbitration award; and

(c) is not to be repaid regardless of the judgment or award.

(3) Nothing in this section restricts the insurer's right of comparative contribution or indemnity in accordance with the laws of this state.

NEW SECTION. Section 17. Availability and effectiveness of health care liability insurance. A health care liability insurance policy written under the provisions of [section 3] may not be canceled or nonrenewed except for nonpayment of premiums or unless the health care provider's license is revoked by the appropriate licensing board. A health care provider whose license is revoked must be permitted to buy out of a claims-made policy.

NEW SECTION. Section 18. Rulemaking authority. The department or commissioner may promulgate rules that are necessary to enable the department or commissioner to perform

1 their respective responsibilities under [sections 1 through
2 32].
3

4 NEW SECTION. Section 19. Injured patients and families
5 compensation fund established -- integrity. (1) There is an
6 injured patients and families compensation fund within the
7 state treasury.

8 (2) Except as provided in subsection (3), all premiums
9 and other money paid to the fund, all property and securities
10 acquired through the use of money belonging to the fund, and
11 all interest and dividends earned on money belonging to the
12 fund are the sole property of the fund and must be used
13 exclusively for the operations and obligations of the fund.
14 The money collected by the fund for claims for injuries
15 occurring on or after [the applicability date of this
16 section] may not be used for any other purpose and may not be
17 transferred by the legislature to other funds or used for
18 other programs. However, fund money must be invested by the
19 board of investments provided for in 2-15-1808 and, subject
20 to the investment agreement with the board of investments,
21 the earnings on investments are the sole property of the fund
22 as provided in this section.

23 (3) The expenditure of money from the fund for
24 administration of the plan, the fund, the board, and the
25 council are considered to be operations of the fund for the
26 purposes of subsection (2).
27

28 NEW SECTION. Section 20. Purpose of fund. (1) The
29 fund is established to curb the rising costs of liability

1 insurance by financing part of the liability incurred by
2 health care providers as a result of medical negligence
3 claims and to ensure that proper claims are satisfied. The
4 purpose of the fund is to pay for:

5 (a) the portion of a medical negligence award or
6 judgment that is in excess of \$500,000 or the maximum
7 liability limit for which the health care provider is
8 insured, whichever limit is greater;

9 (b) future medical expense payments under [section 12];
10 and

11 (c) claims under [section 25].

12 (2) The fund provides occurrence coverage for:

13 (a) a claim against a health care provider that has
14 complied with [sections 1 through 32];

15 (b) a claim against an employee of a health care
16 provider that has complied with [sections 1 through 32];

17 (c) reasonable and necessary expenses incurred in the
18 payment of claims; and

19 (d) the administrative expenses of the fund.

20 (3) The coverage provided by the fund begins [the
21 applicability date of this section].
22

23 NEW SECTION. Section 21. Board of governors --
24 appointments -- compensation. (1) There is a health care
25 liability insurance plan board of governors.

26 (2) The board is allocated to the insurance department
27 established in 2-15-1902 for administrative purposes only as
28 prescribed in 2-15-121.

29 (3) The board is composed of:

1 (a) three representatives of the insurance industry
2 appointed by and to serve at the pleasure of the
3 commissioner;

4 (b) one person to be named by the state bar of Montana;

5 (c) one person to be named by the Montana trial lawyers
6 association;

7 (d) two persons to be named by the Montana medical
8 association;

9 (e) one person to be named by the Montana hospital
10 association;

11 (f) the commissioner or the commissioner's designated
12 representative. If the commissioner appoints a designated
13 representative, the representative must be employed by the
14 office of the commissioner. The commissioner or the
15 commissioner's representative serves as the presiding officer
16 of the board.

17 (g) four public members, at least two of whom are not
18 attorneys or physicians and are not professionally affiliated
19 with any health care facility or insurance company, appointed
20 by the governor.

21 (4) (a) Except as provided in subsections (4) (b) and
22 (5), each member of the board, except the insurance
23 commissioner, serves for a term of 3 years and may not serve
24 for more than two consecutive terms.

25 (b) A vacancy on the board must be filled in the same
26 manner as the original appointment and the term of the person
27 appointed to fill the vacancy expires on the date of the
28 original appointee's term.

29 (5) A member may be removed from the board only for

malfeasance, misfeasance, or nonfeasance, as determined by a
3/4 majority of the board or by a court of competent
jurisdiction.

(6)(a) Except as provided in subsection (6)(b), each
board member is compensated at the rate of \$50 for each day
of board business conducted by the member and approved by the
board, plus expenses as provided for in 2-18-501 through 2-
18-503.

(b) A board member who is an employee of the state or
any subdivision of the state may not be compensated under
this section but is eligible to be reimbursed for expenses as
provided in 2-18-501 through 2-18-503.

NEW SECTION. **Section 22. Fund administration and
operation.** (1) Management of the fund is vested in the
board.

(2) The commissioner shall, for the operation of the
fund:

(a) provide all staff services as necessary; or
(b) with the approval of the board, contract for all or
part of the services.

(3) For the purposes of carrying out its functions and
the purposes of [sections 1 through 32], the board may:

(a) sue and be sued;
(b) enter into contracts relating to the administration
of the fund, including claims management, servicing, and
payment;
(c) collect and disburse money received;
(d) as provided for in [section 23], adopt

1 classifications and charge premiums for the classifications
2 so that the fund will be neither more nor less than
3 self-supporting. The classifications and the initial premium
4 rates for the classifications must be adopted pursuant to
5 Title 2, chapter 4, parts 2 through 4. Subsequent to
6 initially adopting the classifications and premiums, the
7 board may change the classifications or premiums by using a
8 method set forth in rules. The contested case rights and
9 provisions of Title 2, chapter 4, do not apply to a health
10 care provider's classification or premium rate. Except as
11 provided in [sections 1 through 32], a person may not,
12 without first obtaining the written permission of the health
13 care provider, use, sell, or distribute the health care
14 provider's specific loss information, including but not
15 limited to experience modification factors.

16 (e) hire personnel;

17 (f) declare dividends if there is an excess of assets
18 over liabilities. However, dividends may not be paid until
19 adequate actuarially determined reserves are set aside.

20 (g) contract with licensed resident insurance
21 producers;

22 (h) expend funds for scholarship, educational, or
23 charitable purposes; and

24 (i) perform all functions and exercise all powers of a
25 private insurance carrier that are necessary, appropriate, or
26 convenient for the administration of the fund.

27 (4) The fund shall include a provision in every policy
28 of insurance issued pursuant to [sections 1 through 32] that
29 incorporates the restriction on the use and transfer of money

1 collected by the fund as provided for in [section 19].

2 (5) Consistent with the provisions of Title 18, the
3 commissioner shall adopt rules governing the procedures for
4 creating and implementing a contract allowed under this
5 section before entering into a contract. A contract executed
6 under this section is subject to all nondiscrimination
7 requirements applicable to public contracts under Title 18.

8 (6) If a contract is awarded under this section, the
9 contractor shall report at least annually to the commissioner
10 and the board all contract-related expenses incurred,
11 including arrangements regarding the subcontracting of
12 services.

13 (7) If the board approves, a contractor may hire legal
14 counsel as needed to provide staff services for
15 administration of the plan or fund.

16
17 NEW SECTION. **Section 23. Premiums for fund.** Each
18 health care provider shall pay to the fund an annual premium
19 based on the following considerations:

20 (1) the past and prospective loss and expense
21 experience in different types of practice;

22 (2) the past and prospective loss and expense
23 experience of the fund;

24 (3) the loss and expense experience of the individual
25 health care provider that resulted in the payment of money,
26 from the fund or other sources, for damages for medical
27 negligence, except that an adjustment to a health care
28 provider's premiums may not be made under this subsection
29 prior to the receipt of the recommendation of the council and

1 the expiration of the time period provided under [section
2 30(4)] for the health care provider to comment, or prior to
3 the expiration of the time period under [section 30(1)];

4 (4) risk factors for a person who is semiretired or a
5 part-time professional;

6 (5) for a health care provider described in [section
7 4(1)(d), (1)(e), or (1)(f)], risk factors and past and
8 prospective loss and expense experience attributable to
9 employees of that health care provider other than an employee
10 licensed as a physician or an advanced practice registered
11 nurse; and

12 (6) other factors considered by the board to promote
13 equity among the health care providers who pay premiums under
14 this section.

15

16 NEW SECTION. Section 24. Fund accounting and audit.

17 (1) The commissioner may expend money from the fund only
18 after approval by the board.

19 (2) All books, records, and audits of the fund, except
20 confidential claims information, are open to the public for
21 reasonable inspection.

22 (3) Every person authorized to receive deposits for,
23 withdraw money from, or otherwise disburse any money from the
24 fund shall post a bond in an amount reasonably sufficient to
25 protect fund assets. The cost of the bond must be paid from
26 the fund.

27 (4) After the close of each fiscal year, the board shall
28 furnish a financial report to the commissioner. The report
29 must be prepared in accordance with generally accepted

1 accounting principles and must include the present value of
2 all claims reserves, including reserves for claims incurred
3 but not reported, and all other information as required by
4 the commissioner. The board shall furnish an appropriate
5 summary of the report to all fund participants.

6 (5) The board shall also prepare and submit to the state
7 board of investments and the department of administration a
8 quarterly report projecting the future cash flow needs of the
9 fund.

10
11 NEW SECTION. Section 25. Claims procedure. (1) A
12 person may file a claim for damages for medical negligence
13 arising out of the rendering of medical care or services
14 within this state against a health care provider or an
15 employee of a health care provider. A person who files a
16 claim may recover from the fund only if the health care
17 provider or the employee of the health care provider has
18 coverage under the fund, the fund is named as a party in the
19 action, and the action against the fund is commenced within
20 the same time limitation within which the action against the
21 health care provider or employee of the health care provider
22 must be commenced.

23 (2)(a) A person may file an action for damages for
24 medical negligence arising out of the rendering of medical
25 care or services outside this state against a health care
26 provider or an employee of a health care provider. A person
27 filing an action under this subsection (2) may recover from
28 the fund only if the health care provider or the employee of
29 the health care provider has coverage under the fund, the

1 fund is named as a party in the action, and the action
2 against the fund is commenced within the same time limitation
3 within which the action against the health care provider or
4 employee of the health care provider must be commenced.

5 (b) If the law or rules of procedure of the
6 jurisdiction in which the action is brought do not permit
7 naming the fund as a party, the person filing the action may
8 recover from the fund only if:

9 (i) the health care provider or the employee of the
10 health care provider has coverage under the fund; and

11 (ii) except as provided in subsection (2)(c), the
12 person filing the action notifies the commissioner, as the
13 representative of the fund, of the action within 60 days of
14 service of process on the health care provider or the
15 employee of the health care provider.

16 (c) The board may extend the 60-day time limit if it
17 finds that enforcement of the time limit would be prejudicial
18 to the purposes of the fund and would not benefit either the
19 insured or the claimant.

20 (3) If, after reviewing the facts upon which the claim
21 or action is based, it appears reasonably probable that
22 damages paid will exceed \$500,000 or the maximum liability
23 limit for which the health care provider is insured,
24 whichever is greater, the board may:

25 (a) appear and actively defend itself whenever the
26 board or the fund is named as a party in an action against a
27 health care provider or an employee of a health care provider
28 that has coverage under the fund;

29 (b) retain counsel; or

1 (c) pay out of the fund attorney fees and expenses,
2 including court costs incurred and awarded in defending the
3 insured, the plan, or the fund.

4 (4) If legal counsel is retained under subsection
5 (3)(b), the attorney or law firm retained may not be retained
6 or employed by the board to perform legal services for the
7 board, other than those services directly connected with
8 defending the insured, the plan, or the fund.

9 (5) A judgment affecting the fund may be appealed as
10 provided by law. The board is not required to file any
11 undertaking in any judicial action, proceeding, or appeal.

12 (6) The insurer or a self-insurer providing,
13 respectively, insurance or self-insurance for a health care
14 provider who is also covered by the fund must provide an
15 adequate defense of the fund on any claim filed that may
16 potentially affect the fund with respect to the insurance
17 contract or self-insurance contract. The insurer or
18 self-insurer shall act in good faith and in a fiduciary
19 relationship with respect to any claim affecting the fund. A
20 settlement that exceeds an amount that could require payment
21 from the fund may not be agreed to unless approved by the
22 board.

23 (7) A health care provider with a cash or surety bond
24 in effect to insure the health care provider against medical
25 negligence shall:

26 (a) provide an adequate defense of the fund on any
27 medical negligence claim filed that may affect the fund; and

28 (b) act in good faith and in a fiduciary relationship
29 with respect to any claim affecting the fund.

1 (8) A person who has recovered a final judgment or a
2 settlement approved by the board against a health care
3 provider or an employee of a health care provider that has
4 coverage under the fund may file a claim with the board to
5 recover the greater of:

6 (a) the portion of the judgment or settlement that is
7 in excess of \$500,000; or

8 (b) the maximum liability limit for which the health
9 care provider is insured.

10 (9)(a) If the fund incurs liability for future payments
11 that exceed \$1 million to any person under a single claim as
12 the result of a settlement or judgment that is entered into
13 or rendered under [sections 1 through 32] for medical
14 negligence that occurred on or after [the applicability date
15 of this section], the board shall pay from the fund, after
16 deducting the reasonable costs of collection attributable to
17 the remaining liability, including attorney fees reduced to
18 present value, all relevant medical expenses each year, plus
19 an amount, not to exceed \$500,000 per year, that will pay the
20 remaining liability over the person's anticipated lifetime or
21 until the liability is paid in full.

22 (b) If the remaining liability is not paid in full
23 before the person dies, the board may pay from the fund the
24 remaining liability in a lump sum.

25 (10) Payments must be made from money collected and
26 paid into the fund under [section 23] and from earnings on
27 the fund.

28 (11)(a) Except as provided in [section 12] or
29 subsection (9)(b), for a claim subject to a periodic payment

1 made under this section, payments must be made until the
2 claim has been paid in full. Periodic payments made under
3 this section include direct or indirect payment or a
4 commitment of money to or on behalf of any person under a
5 single claim by any funding mechanism.

6 (b) Except as provided in subsection (11)(c), interest
7 on a claim is not paid by the fund.

8 (c) If there is an offer of settlement by a claimant
9 under this section that is not accepted and the claimant
10 recovers a judgment that is greater than or equal to the
11 amount specified in the offer of settlement, the claimant is
12 entitled to interest at the annual rate of 12% on the full
13 amount recovered. Interest accrues from the date of the
14 offer of settlement until the amount of the settlement, plus
15 the accrued interest, is paid in full.

16 (12)(a) Claims payable from the fund must be paid in the
17 order received within 90 days after filing unless appealed by
18 the board.

19 (b) If the amount of money in the fund is insufficient
20 to pay all of the payable claims, payable claims received
21 after the amount in the fund is exhausted are payable
22 immediately in the following year in the order in which the
23 payable claims were received.

24
25 NEW SECTION. **Section 26. Fund income -- reports --**
26 **reinsurance.** (1) All income derived from investments of the
27 fund's assets must be credited to the fund.

28 (2) On or before December 31 of each year, the board
29 shall submit a report on the financial and operational status

1 of the fund to the legislature as provided in 5-11-210.

2 (3) Subject to approval by the commissioner, the board
3 may cede reinsurance to an insurer authorized to do business
4 in this state or pursue other loss-funding management to
5 preserve the solvency and integrity of the fund. The
6 commissioner may prescribe controls over or other conditions
7 on the use of reinsurance or other loss-funding management
8 mechanisms.

9
10 NEW SECTION. Section 27. Actions against insurers,
11 self-insurers, or providers. The board may bring an action
12 against an insurer, self-insurer, or health care provider for
13 failure to act in good faith or breach of fiduciary
14 responsibility under [section 25(6) or (7)].

15
16 NEW SECTION. Section 28. Injured patients and families
17 compensation fund peer review council -- members -- meetings
18 -- assessments -- compensation -- report. (1) There is an
19 injured patients and families compensation fund peer review
20 council.

21 (2)(a) The board shall appoint five individuals to
22 serve as the council.

23 (b) No more than three of the appointees may be
24 physicians who are actively engaged in the practice of
25 medicine in this state.

26 (c) The board shall annually designate:

27 (i) the presiding officer of the council who:

28 (A) must be a physician; and

29 (B) serves as an ex officio, nonvoting member of the

1 board of medical examiners; and

2 (ii) the vice presiding officer of the council and the
3 secretary of the council.

4 (3) A majority of the members of the council
5 constitutes a quorum for the purpose of conducting business.

6 (4) Council members serve staggered 3-year terms. A
7 council member may not serve for more than two consecutive
8 terms.

9 (5) The council shall meet at the call of the presiding
10 officer of the council, the presiding officer of the board,
11 or by an affirmative vote of at least three members of the
12 council. The council shall meet in Helena or at an alternate
13 location determined by the presiding officer who calls or the
14 members who call the meeting.

15 (6) Assessments sufficient to cover the council's
16 costs, including costs of administration, must be imposed and
17 collected as provided in [section 29].

18 (7)(a) Members of the council must be paid at a rate
19 established by the board by rule. The rate established by
20 the board must be the same rate for all members.

21 (b) A person acting as a consultant to the council must
22 be paid at a rate established by the commissioner by rule.

23 (8)(a) Except as provided in subsection (8)(b), the
24 council shall submit annually to the presiding officer of the
25 board a report on the operation of the council.

26 (b) The board or the commissioner may at any time
27 direct the council to submit a report on the operation of the
28 council. A report directed under this subsection (8)(b) must
29 be submitted within 60 days following the direction to submit

1 the report.

2

3 NEW SECTION. Section 29. Assessments for peer review
4 council. (1) The fund and each private health care liability
5 insurer, including health care liability self-insurers, shall
6 pay to the fund an annual assessment in support of the
7 council. The total amount of the assessments must be
8 sufficient to cover the costs of the council, including costs
9 of administration, for reviewing claims paid by the fund,
10 plan, and insurer, respectively, under [section 30].

11 (2) The commissioner, after approval by the board,
12 shall set by rule the amount of the assessments imposed under
13 subsection (1).

14 (3) (a) Except as provided in subsection (3) (b), the
15 assessments must be paid quarterly as established by the
16 commissioner.

17 (b) An assessment for a period of time less than 1
18 calendar or fiscal quarter must be prorated by the
19 commissioner.

20 (4) This section does not impose liability on the board
21 for payment of any part of a fund deficit.

22 (5) Except as provided in subsection (6), the rules may
23 not provide for more than four assessment classifications for
24 physicians and each classification may only be based on:

25 (a) the amount of surgery performed; and

26 (b) the risk of diagnostic and therapeutic services
27 provided or procedures performed.

28 (6) In addition to the assessment classifications, the
29 commissioner, after approval by the board, may establish by

1 rule a separate assessment classification for physicians
2 satisfying [section 4(1)(b)] and a separate assessment for
3 advanced practice registered nurses satisfying [section
4 4(1)(b)] that take into account the loss experience of health
5 care providers for whom an adjacent state is a principal
6 place of practice.

7 (7)(a) Except as provided in subsection (7)(b), every
8 assessment established by rule pursuant to this section must
9 provide for an automatic increase in a health care provider's
10 assessment if the loss and expense experience of the fund and
11 other sources with respect to the health care provider or an
12 employee of the health care provider exceeds a threshold
13 number of claims paid or a threshold dollar volume of claims
14 paid as either threshold is established in the rules. The
15 rules must also specify applicable amounts of increase
16 corresponding to the number of claims paid and the dollar
17 volume of awards in excess of the respective thresholds for
18 the number of claims paid or the dollar volume of claims
19 paid.

20 (b) The rules must provide that the automatic increase
21 does not apply if the board determines that the performance
22 of the council in making recommendations under [section 30]
23 adequately addresses the consideration set forth in
24 subsection (6).

25 (8) The rules setting assessments for a particular
26 fiscal year must ensure that the total amount of assessments
27 does not exceed the greatest of the following:

28 (a) the estimated total dollar amount of claims to be
29 paid during the particular fiscal year;

1 (b) the total amount assessed on all health care
2 providers for the fiscal year preceding the particular fiscal
3 year, adjusted by the commissioner to reflect changes in the
4 consumer price index for all urban consumers, U.S. city
5 average, for the medical care group, as determined by the
6 U.S. department of labor, and changes in the number of health
7 care providers covered by the plan; or

8 (c) 200% of the total dollar amount disbursed for
9 claims during the calendar year preceding the particular
10 fiscal year.

11 (9) Assessments imposed under subsections (1) and (2)
12 and future medical expense payments payable by the fund under
13 [section 12] must be collected by the commissioner for
14 deposit into the fund in a manner prescribed by the
15 commissioner by rule.

16 (10)(a) If the rules establishing assessments under
17 subsection (2) do not take effect prior to July 2 of any
18 fiscal year, the commissioner may collect assessments at the
19 rates established for the previous fiscal year.

20 (b) Subject to subsection (10)(c), if the commissioner
21 collects assessments pursuant to subsection (10)(a) and the
22 rules promulgated under subsection (2) become effective after
23 July 1, the assessments must be adjusted to reflect the
24 assessments established pursuant to subsection (2).

25 (c) The commissioner may choose to refund, adjust for,
26 or not collect minimal amounts, as established by rule.

27
28 NEW SECTION. Section 30. Claims review by council --
29 recommendations. (1) For damages arising out of medical

1 negligence for the rendering of medical care by a health care
2 provider or an employee of the health care provider, the
3 council shall review, within 1 year of the date of first
4 payment from the fund of the damages, each claim that is paid
5 by:

- 6 (a) the fund;
- 7 (b) the mandatory plan established under [section 3];
- 8 (c) a private health care liability insurer; or
- 9 (d) a self-insurer.

10 (2) The council shall make recommendations to all of
11 the following:

- 12 (a) the commissioner and the board regarding any
13 adjustments to be made, under [section 29(6)], to the
14 assessment against the health care provider, based on the
15 paid claim;
- 16 (b) the commissioner and the board regarding any
17 adjustments to be made, under [section 23(3)], to premiums
18 assessed against a physician under the mandatory plan
19 established under [section 3], based on the paid claim; and
- 20 (c) a private health care liability insurer, if
21 requested by the private insurer, regarding adjustments to
22 premiums assessed against a physician covered by private
23 insurance, based on the paid claim.

24 (3) In developing recommendations under subsection (2),
25 the council may consult with any person and shall consult
26 with the following:

- 27 (a) if a claim was paid for damages arising out of the
28 rendering of care by a physician, with at least one physician
29 from the area of medical specialty of the physician who

1 rendered the care and with at least one physician from the
2 area of medical specialty of the medical procedure involved,
3 if the specialty area of the procedure is different from the
4 specialty area of the physician who rendered the care; or

5 (b) if a claim was paid for damages arising out of the
6 rendering of care by an advanced practice registered nurse,
7 with at least one advanced practice registered nurse.

8 (4) The council shall notify, in writing, the affected
9 health care provider of the council's recommendations to the
10 commissioner, the board, or a private insurer made under
11 subsection (2). The notice must inform the health care
12 provider that the health care provider may submit written
13 comments on the council's recommendations to the
14 commissioner, the board, or the private insurer within a
15 reasonable period of time as specified in the notice.

16 (5) A person consulting with the council under
17 subsection (3) must be paid at a rate established by the
18 commissioner by rule.

19
20 NEW SECTION. **Section 31. Review of patient records.**

21 (1) The council may obtain any information relating to any
22 claim it reviews under [sections 28 through 32] that is in
23 the possession of the commissioner or the board.

24 (2) The council shall keep patient health care
25 information confidential and the records are exempt from the
26 provisions of Title 2, chapter 6.

27
28 NEW SECTION. **Section 32. Council immunity.** Members of
29 the council and any person consulting with the council under

1 [section 30(3)] are immune from civil liability for acts or
2 omissions while performing their duties under [sections 28
3 through 32].
4

5 Section 33. Section 2-15-1731, MCA, is amended to read:

6 "2-15-1731. Board of medical examiners. (1) There is a
7 Montana state board of medical examiners.

8 (2)(a) The board consists of:

9 (i) 11 members appointed by the governor with the
10 consent of the senate; and

11 (ii) the presiding officer of the injured patients and
12 families compensation fund peer review council established in
13 [section 28] who serves as a nonvoting member.

14 (b) Appointments made by the governor when the
15 legislature is not in session may be confirmed at the next
16 session of the legislature under the rules of the senate then
17 in effect.

18 (3) The members appointed by the governor are:

19 (a) five members having the degree of doctor of
20 medicine;

21 (b) one member having the degree of doctor of
22 osteopathy;

23 (c) one member who is a licensed podiatrist;

24 (d) one member who is a licensed nutritionist;

25 (e) one member who is a licensed physician
26 assistant-certified; and

27 (f) two members of the general public who are not
28 medical practitioners.

29 (4) The No two members listed in subsection (3)(a)

1 having the degree of doctor of medicine may not be from the
2 same county. Each member appointed by the governor must be a
3 citizen of the United States. Each member appointed by the
4 governor, except for public members, must have been licensed
5 and must have practiced medicine or dietetics-nutrition in
6 this state for at least 5 years and must have been a resident
7 of this state for at least 5 years.

8 (5) Members appointed by the governor shall serve
9 staggered 4-year terms. A term commences on September 1 of
10 each year of appointment. A member appointed by the governor
11 may, upon notice and hearing, be removed by the governor for
12 neglect of duty, incompetence, or unprofessional or
13 dishonorable conduct.

14 (6) The board is allocated to the department for
15 administrative purposes only as prescribed in 2-15-121."

16 {Internal References to 2-15-1731:

17 37-3-102 37-6-101 37-20-201 37-20-401
18 50-6-202 ok ddb 6/8}

19
20 **Section 34.** Section 17-6-201, MCA, is amended to read:

21 **"17-6-201. Unified investment program -- general**
22 **provisions.** (1) The unified investment program directed by
23 Article VIII, section 13, of the Montana constitution to be
24 provided for public funds must be administered by the board
25 of investments in accordance with the prudent expert
26 principle, which requires an investment manager to:

27 (a) discharge the duties with the care, skill,
28 prudence, and diligence, under the circumstances then
29 prevailing, that a prudent person acting in a like capacity
30 with the same resources and familiar with like matters

1 exercises in the conduct of an enterprise of a like character
2 with like aims;

3 (b) diversify the holdings of each fund within the
4 unified investment program to minimize the risk of loss and
5 to maximize the rate of return unless, under the
6 circumstances, it is clearly prudent not to do so; and

7 (c) discharge the duties solely in the interest of and
8 for the benefit of the funds forming the unified investment
9 program.

10 (2) (a) Retirement funds may be invested in common
11 stocks of any corporation.

12 (b) Other public funds may not be invested in private
13 corporate capital stock. "Private corporate capital stock"
14 means only the common stock of a corporation.

15 (3) (a) This section does not prevent investment in any
16 business activity in Montana, including activities that
17 continue existing jobs or create new jobs in Montana.

18 (b) The board is urged under the prudent expert
19 principle to invest up to 3% of retirement funds in venture
20 capital companies. Whenever possible, preference should be
21 given to investments in those venture capital companies that
22 demonstrate an interest in making investments in Montana.

23 (c) In discharging its duties, the board shall consider
24 the preservation of purchasing power of capital during
25 periods of high monetary inflation.

26 (d) The board may not make a direct loan to an
27 individual borrower. The purchase of a loan or a portion of a
28 loan originated by a financial institution is not considered
29 a direct loan.

1 (4) The board has the primary authority to invest state
2 funds. Another agency may not invest state funds unless
3 otherwise provided by law. The board shall direct the
4 investment of state funds in accordance with the laws and
5 constitution of this state. The board has the power to veto
6 investments made under its general supervision.

7 (5) The board shall:

8 (a) assist agencies with public money to determine if,
9 when, and how much surplus cash is available for investment;

10 (b) determine the amount of surplus treasury cash to be
11 invested;

12 (c) determine the type of investment to be made;

13 (d) prepare the claim to pay for the investment; and

14 (e) keep an account of the total of each investment
15 fund and of all the investments belonging to the fund and a
16 record of the participation of each treasury fund account in
17 each investment fund; and

18 (f) invest the money held in the injured patients and
19 families compensation fund in investments with maturities and
20 liquidity that are appropriate and necessary to meet the
21 needs of the fund, including cash flow needs, as reported
22 under [section 24].

23 (6) The board may:

24 (a) execute deeds of conveyance transferring real
25 property obtained through investments. Prior to the transfer
26 of real property directly purchased and held as an
27 investment, the board shall obtain an appraisal by a
28 qualified appraiser.

29 (b) direct the withdrawal of funds deposited by or for

the state treasurer pursuant to 17-6-101 and 17-6-105;

(c) direct the sale of securities in the program at their full and true value when found necessary to raise money for payments due from the treasury funds for which the securities have been purchased.

(7) The cost of administering and accounting for each investment fund must be deducted from the income from each fund."

{ Internal References to 17-6-201:

10-2-703	17-6-305	17-6-308	17-6-308
77-1-101	77-1-701	77-1-905	80-6-315
80-7-816	80-8-116	80-10-207	80-15-302 ok ddb 6/8 }

Section 35. Section 17-6-203, MCA, is amended to read:

"17-6-203. Separate investment funds. Separate investment funds must be maintained as follows:

(1) the permanent funds, including all public school funds and funds of the Montana university system and other state institutions of learning referred to in Article X, sections 2 and 10, of the Montana constitution. The principal and any part of the principal of each fund constituting the Montana permanent fund type are subject to deposit at any time when due under the statutory provisions applicable to the fund and according to the provisions of the gift, donation, grant, legacy, bequest, or devise through or from which the particular fund arises.

(2) a separate investment fund, which may not be held jointly with other funds, for money pertaining to each retirement or insurance system maintained by the state, including:

1 (a) the highway patrol officers' retirement system
2 described in Title 19, chapter 6;

3 (b) the public employees' retirement system described
4 in Title 19, chapter 3;

5 (c) the game wardens' and peace officers' retirement
6 system described in Title 19, chapter 8;

7 (d) the teachers' retirement system described in Title
8 19, chapter 20; and

9 (e) the workers' compensation program described in
10 Title 39, chapter 71, part 23; and

11 (f) the injured patients and families compensation fund
12 established in [section 19];

13 (3) a pooled investment fund, including all other
14 accounts within the treasury fund structure established by
15 17-2-102;

16 (4) the fish and wildlife mitigation trust fund
17 established by 87-1-611;

18 (5) a fund consisting of gifts, donations, grants,
19 legacies, bequests, devises, and other contributions made or
20 given for a specific purpose or under conditions expressed in
21 the gift, donation, grant, legacy, bequest, devise, or
22 contribution to be observed by the state of Montana. If a
23 gift, donation, grant, legacy, bequest, devise, or
24 contribution permits investment and is not otherwise
25 restricted by its terms, it may be treated jointly with other
26 gifts, donations, grants, legacies, bequests, devises, or
27 contributions.

28 (6) a fund consisting of coal severance taxes allocated
29 to the coal severance tax trust fund under Article IX,

1 section 5, of the Montana constitution. The principal of the
2 coal severance tax trust fund is permanent. If the
3 legislature appropriates any part of the principal of the
4 coal severance tax trust fund by a vote of three-fourths of
5 the members of each house, the appropriation or investment
6 may create a gain or loss in the principal.

7 (7) a Montana tobacco settlement trust fund established
8 in accordance with Article XII, section 4, of the Montana
9 constitution and Title 17, chapter 6, part 6; and

10 (8) additional investment funds that are expressly
11 required by law or that the board of investments determines
12 are necessary to fulfill fiduciary responsibilities of the
13 state with respect to funds from a particular source."

14 {Internal References to 17-6-203:

15 15-1-402	15-35-108	15-35-108	15-35-108
16 17-6-202	17-6-202	17-6-305	17-6-331
17 20-9-466 ok ddb 6/8}			

18
19 **Section 36.** Section 25-9-402, MCA, is amended to read:

20 **"25-9-402. Findings by trier of fact -- civil actions.**
21 ~~In~~ Except as provided in [section 12], in any action for
22 personal injury, property damage, or wrongful death where
23 liability is found after trial and in which \$100,000 or more
24 in future damages is awarded to the claimant, the trier of
25 fact shall make a separate finding as to the amount of any
26 future damages so awarded and state whether the amount of
27 future damages has been reduced to present value."

28 {Internal References to 25-9-402: None. ok ddb 9/10}
29

30 **Section 37.** Section 25-9-403, MCA, is amended to read:

1 "25-9-403. Request for periodic payment of future

2 damages -- nonmalpractice claims. (1) Except as provided in
3 25-9-412 and [section 12], a party to an action for personal
4 injury, property damage, or wrongful death in which \$100,000
5 or more of future damages is awarded may, prior to the entry
6 of judgment, request the court to enter a judgment ordering
7 future damages to be paid in whole or in part by periodic
8 payments rather than by a lump-sum payment. Upon a request,
9 the court may enter an order for periodic payment of future
10 damages if the court finds that periodic payment is in the
11 best interests of the claimant. The total dollar amount of
12 the ordered periodic payments must equal the total dollar
13 amount of the future damages without a reduction to present
14 value.

15 (2) A court ordering the payment of future damages by
16 periodic payments shall make specific findings as to the
17 dollar amount of periodic payments needed to compensate the
18 judgment creditor for future damages and as to whether an
19 order for periodic payment of future damages is in the best
20 interests of the claimant.

21 (3) The judgment order must specify the recipient or
22 recipients of periodic payments, the dollar amount of the
23 payments, the interval between payments, and the number of
24 payments or the period of time over which payments must be
25 made.

26 (4) A court ordering periodic payment of future damages
27 shall order that the payments be made, during the life of the
28 judgment creditor or during the continuance of the
29 compensable injury or disability of the judgment creditor,

1 through the purchase of an inflation-indexed annuity approved
2 by the court. The annuity must be in the form of an
3 inflation-indexed annuity contract purchased from a qualified
4 insurer that, in the most recent edition of A.M. Best, has an
5 "A" (excellent) or higher rating and is in a class 7 or
6 higher classification. The annuity also serves as any
7 required supersedeas bond. Upon purchase of a court-approved
8 annuity, the court may order that the judgment is satisfied
9 and that the judgment debtor is discharged. If the judgment
10 creditor dies before all periodic payments have been made,
11 the remaining payments become the property of the creditor's
12 estate."

13 {Internal References to 25-9-403: None. ok ddb 6/10}

14
15 **Section 38.** Section 25-9-412, MCA, is amended to read:

16 **"25-9-412. Periodic payment of future damages in**
17 **medical malpractice cases. (1)(a) A With respect to an act of**
18 **malpractice that occurred prior to [the effective date of**
19 **this section], a party to an action for a malpractice claim,**
20 **as defined in 25-9-411, in which \$50,000 or more of future**
21 **damages is awarded may, prior to the entry of judgment,**
22 **request the court to enter a judgment ordering future damages**
23 **to be paid in whole or in part by periodic payments rather**
24 **than by a lump-sum payment. Upon a request, the court shall**
25 **enter an order for periodic payment of future damages. The**
26 **total dollar amount of the ordered periodic payments must**
27 **equal the total dollar amount of the future damages without a**
28 **reduction to present value.**

29 **(b) With respect to an act of malpractice that occurred**

1 on or after [the effective date of this section], the
2 provisions of [section 12] apply.

3 (2) A court ordering the payment of future damages by
4 periodic payments shall make specific findings as to the
5 dollar amount of periodic payments needed to compensate the
6 judgment creditor for future damages.

7 (3) The judgment order must specify the recipient or
8 recipients of periodic payments, the dollar amount of the
9 payments, the interval between payments, and the number of
10 payments or the period of time over which payments must be
11 made.

12 (4) The court shall order that periodic payment of
13 future damages be made, during the life of the judgment
14 creditor or during the continuance of the compensable injury
15 or disability of the judgment creditor, through the purchase
16 of an inflation-indexed annuity approved by the court. The
17 annuity must be in the form of an inflation-indexed annuity
18 contract purchased from a qualified insurer that, in the most
19 recent edition of A.M. Best, has an "A" (excellent) or higher
20 rating and is in a class 7 or higher classification. The
21 annuity also serves as any required supersedeas bond. Upon
22 purchase of a court-approved annuity, the court shall order
23 that the judgment is satisfied and that the judgment debtor
24 is discharged. If the judgment creditor dies before all
25 periodic payments have been made, the remaining payments
26 become the property of the creditor's estate."

27 {Internal References to 25-9-412:
28 25-9-403 ok ddb 6/10}

Section 39. Section 27-6-103, MCA, is amended to read:

"27-6-103. Definitions. As used in this chapter, the following definitions apply:

(1) "Advance practice registered nurse" has the meaning provided in [section 2] and includes:

(a) an advance practice registered nurse who has liability coverage under the Montana health care liability insurance plan established pursuant to [section 3]; and

(b) a person who at the time of the occurrence of the incident giving rise to the claim:

(i) was an individual who had as the principal residence or place of practice the state of Montana and was not employed full-time by any federal governmental agency or entity; or

(ii) was a professional service corporation, partnership, or other business entity organized under the laws of any state to render services of advance practice registered nurses and whose shareholders, partners, or owners were individual advance practice registered nurses licensed to practice under the provisions of Title 37, chapter 8.

~~(1)~~ (2) "Dentist" means:

(a) for purposes of the assessment of the annual surcharge, an individual licensed to practice dentistry under the provisions of Title 37, chapter 4, who at the time of the assessment:

(i) has as the individual's principal residence or place of dental practice the state of Montana;

(ii) is not employed full-time by any federal governmental agency or entity; and

1 (iii) is not fully retired from the practice of
2 dentistry; or

3 (b) for all other purposes, a person licensed to
4 practice dentistry under the provisions of Title 37, chapter
5 4, who at the time of the occurrence of the incident giving
6 rise to the claim:

7 (i) was an individual who had as the principal
8 residence or place of dental practice the state of Montana
9 and was not employed full-time by any federal governmental
10 agency or entity; or

11 (ii) was a professional service corporation,
12 partnership, or other business entity organized under the
13 laws of any state to render dental services and whose
14 shareholders, partners, or owners were individual dentists
15 licensed to practice dentistry under the provisions of Title
16 37, chapter 4.

17 ~~(2)~~(3) (a) "Health care facility" means a facility,
18 other than a governmental infirmary but including a
19 university or college infirmary, licensed as a health care
20 facility under Title 50, chapter 5.

21 (b) For the purposes of this chapter, a health care
22 facility does not include an end-stage renal dialysis
23 facility, a home infusion therapy agency, or a residential
24 care facility if the alleged malpractice occurred prior to
25 [the effective date of this section].

26 ~~(3)~~(4) "Health care provider" means a physician, a
27 dentist, a podiatrist, an advance practice registered nurse,
28 or a health care facility.

29 ~~(4)~~(5) "Hospital" means a hospital as defined in

50-5-101.

~~(5)~~(6) "Malpractice claim" means a claim or potential claim of a claimant against a health care provider for medical or dental treatment, lack of medical or dental treatment, or other alleged departure from accepted standards of health care that proximately results in damage to the claimant, whether the claimant's claim or potential claim sounds in tort or contract, and includes but is not limited to:

(a) allegations of battery or wrongful death; and

(b) medical negligence, as defined in [section 2].

~~(6)~~(7) "Panel" means the Montana medical legal panel provided for in 27-6-104.

~~(7)~~(8) "Physician" means:

(a) for purposes of the assessment of the annual surcharge, an individual licensed to practice medicine under the provisions of Title 37, chapter 3, who at the time of the assessment:

(i) (A) has as the individual's principal residence or place of medical practice the state of Montana;

~~(ii)~~(B) is not employed full-time by any federal governmental agency or entity; and

~~(iii)~~(C) is not fully retired from the practice of medicine; or

(ii) is a physician, as defined in [section 2], who has liability coverage under the Montana health care liability insurance plan established pursuant to [section 3]; or

(b) for all other purposes, a person licensed to practice medicine under the provisions of Title 37, chapter

1 3, who at the time of the occurrence of the incident giving
2 rise to the claim:

3 (i) was an individual who had as the principal
4 residence or place of medical practice the state of Montana
5 and was not employed full-time by any federal governmental
6 agency or entity; or

7 (ii) was a professional service corporation,
8 partnership, or other business entity organized under the
9 laws of any state to render medical services and whose
10 shareholders, partners, or owners were individual physicians
11 licensed to practice medicine under the provisions of Title
12 37, chapter 3.

13 ~~(8)~~(9) "Podiatrist" means:

14 (a) for purposes of the assessment of the annual
15 surcharge, an individual licensed to practice podiatry under
16 the provisions of Title 37, chapter 6, who at the time of the
17 assessment:

18 (i) (A) has as the individual's principal residence or
19 place of podiatric practice the state of Montana;

20 ~~(ii)~~(B) is not employed full-time by any federal
21 governmental agency or entity; and

22 ~~(iii)~~(C) is not fully retired from the practice of
23 podiatry; or

24 (ii) has liability coverage under the Montana health
25 care liability insurance plan established pursuant to
26 [section 3]; or

27 (b) for all other purposes, a person licensed to
28 practice podiatry under the provisions of Title 37, chapter
29 6, who at the time of the occurrence of the incident giving

1 rise to the claim:

2 (i) was an individual who had as the principal
3 residence or place of podiatric practice the state of Montana
4 and was not employed full-time by any federal governmental
5 agency or entity; or

6 (ii) was a professional service corporation,
7 partnership, or other business entity organized under the
8 laws of any state to render podiatric services and whose
9 shareholders, partners, or owners were individual podiatrists
10 licensed to practice podiatry under the provisions of Title
11 37, chapter 6."

12 {Internal References to 27-6-103: None. ok ddb 6/8}

13
14 **Section 40.** Section 27-6-105, MCA, is amended to read:

15 **"27-6-105. What claims panel to review.** The panel
16 shall review all malpractice claims or potential claims:

17 (1) filed after April 19, 1977, and before [the
18 effective date of this section] against health care providers
19 covered by this chapter except those claims subject to a
20 valid arbitration agreement allowed by law or upon which suit
21 has been filed prior to April 19, 1977 a physician, as
22 defined in 37-3-102, a dentist licensed to practice dentistry
23 under the provisions of Title 37, chapter 4, a podiatrist
24 licensed to practice podiatry under the provisions of Title
25 37, chapter 6, or a health care facility, provided those
26 claims were not subject to a valid arbitration agreement
27 allowed by law; and

28 (2) filed on or after [the effective date of this
29 section] against a health care provider, as defined in

1 [section 2]."

2 {Internal References to 27-6-105: None. ok ddb 6/9}

3
4 **Section 41.** Section 27-6-606, MCA, is amended to read:

5 **"27-6-606. Decision not binding -- settlement**
6 **agreements -- nonbinding mediation.** (1) The panel's decision
7 is without administrative or judicial authority and is not
8 binding upon any party.

9 (2) The panel may recommend an award, approve
10 settlement agreements, and discuss the settlement agreements,
11 all in a manner consistent with this part. All approved
12 settlement agreements are binding on the parties.

13 (3) If the panel decides both questions required by
14 27-6-602 in the affirmative and a complaint is filed in
15 district court, the court in which the complaint is filed
16 shall, at the request of a party, require the parties to
17 participate in court-supervised, nonbinding mediation prior
18 to proceeding."

19 {Internal References to 27-6-606:
20 27-6-604 ok ddb 6/9}

21
22 **Section 42.** Section 33-1-311, MCA, is amended to read:

23 **"33-1-311. General powers and duties.** (1) The
24 commissioner shall enforce the applicable provisions of the
25 laws of this state and shall execute the duties imposed on
26 the commissioner by the laws of this state.

27 (2) The commissioner has the powers and authority
28 expressly conferred upon the commissioner by or reasonably
29 implied from the provisions of the laws of this state.

1 (3) The commissioner shall administer the department to
2 ensure that the interests of insurance consumers are
3 protected.

4 (4) The commissioner may conduct examinations and
5 investigations of insurance matters, in addition to
6 examinations and investigations expressly authorized, as the
7 commissioner considers proper, to determine whether any
8 person has violated any provision of the laws of this state
9 or to secure information useful in the lawful administration
10 of any provision. The cost of additional examinations and
11 investigations must be borne by the state.

12 (5) The commissioner shall maintain as confidential any
13 information or document received from:

14 (a) the national association of insurance
15 commissioners; or

16 (b) an insurance department from another state or
17 federal agency that treats the same information or document
18 as confidential. The commissioner may provide information or
19 documents, including information or documents that are
20 confidential, to the national association of insurance
21 commissioners, a state or federal law enforcement agency, a
22 federal agency, or an insurance department in another state,
23 if the recipient agrees to maintain the confidentiality of
24 the information or documents.

25 (6) The commissioner shall establish a plan of health
26 care liability coverage for health care providers as required
27 under [section 3].

28 ~~(6)~~(7) The department is a criminal justice agency as
29 defined in 44-5-103."

{ Internal References to 33-1-311:
33-17-1204 ok ddb 6/9 }

NEW SECTION. Section 43. Two-thirds vote required --
contingent voidness. Because [section 32] limits
governmental liability, Article II, section 18, of the
Montana constitution requires a vote of two-thirds of the
members of each house of the legislature for [section 32] to
become effective. If [this act] is not approved by at least
two-thirds of the members of each house of the legislature,
then [section 32] is void.

NEW SECTION. Section 44. {standard} Saving clause.
[This act] does not affect rights and duties that matured,
penalties that were incurred, or proceedings that were begun
before [the effective date of this act].

NEW SECTION. Section 45. {standard} Effective dates.
(1) Except as provided in subsection (2), [this act] is
effective July 1, 2005.

(2) [Sections 36 through 41] are effective January 1,
2006.

NEW SECTION. Section 46. Applicability. Sections 4
through 9, 11 through 13, 16, 17, 25, 27, and 47(6) apply
January 1, 2006.

NEW SECTION. Section 47. Transition. (1) Under
[section 15], an insurer may not enter into or issue any

1 health care liability insurance policy until the insurer's
2 policy form has been submitted to and approved by the
3 commissioner as provided in Title 33, chapter 1, part 5.
4 However, a health care liability insurance policy legally
5 issued or entered into prior to January 1, 2006, is valid
6 unless voided by the insurance commissioner and is, after
7 December 31, 2005, subject to the provisions of [this act].
8 Every health care liability insurance policy in effect on
9 January 1, 2006, is subject to the to the provisions of [this
10 act].

11 (2) [Section 21] requires the appointment of members to
12 the health care liability insurance plan board of governors.
13 All the appointments must be made by August 1, 2005. Upon
14 expiration of the initial term of appointment under this
15 subsection (2), all subsequent terms of appointment are for 3
16 years. For the purposes of transition:

17 (a) the person appointed by the state bar of Montana
18 shall serve until January 1, 2007;

19 (b) the person appointed by the Montana trial lawyers
20 association shall serve until January 1, 2008;

21 (c) one person appointed by the Montana medical
22 association shall serve until January 1, 2007, and the second
23 person appointed by the Montana medical association shall
24 serve until January 1, 2008;

25 (d) one person appointed by the Montana hospital
26 association shall serve until January 1, 2008, and the second
27 person appointed by the Montana hospital association shall
28 serve until January 1, 2009; and

29 (e) the governor shall make two of the required

1 appointments for terms that expire on January 1, 2007, one of
2 the appointments to expire on January 1, 2008, and one of the
3 appointments to expire on January 1, 2009.

4 (3) [Section 23] requires each health care provider to
5 pay to the fund an annual premium for the purposes of the
6 Health Care Liability and Injured Patients Compensation Act.
7 The insurance commissioner and the board of governors of the
8 health care liability insurance plan shall as soon as
9 practicable but no later than December 31, 2005, establish
10 and collect the premiums necessary to establish and
11 administer the injured patients and families compensation
12 fund. The premiums established pursuant to [section 23] and
13 this section are effective upon approval by the board of
14 governors and are effective until new premiums are set as
15 provided in [section 23].

16 (4) [Section 28] requires the board of governors of the
17 health care liability insurance plan to appoint five
18 individuals as the injured patients and families compensation
19 fund peer review council. For the initial appointments, the
20 board shall appoint one individual to serve until January 1,
21 2007, two individuals to serve until January 1, 2008, and two
22 individuals to serve until January 1, 2009.

23 (5) [Section 33] revises the composition of the board
24 of medical examiners to include the presiding officer of the
25 injured patients and families compensation fund peer review
26 council provided for in [section 28]. All legal actions of
27 the board of medical examiners are effective regardless of
28 whether or not the presiding officer of the council has been
29 appointed under [section 28] and, by the appointment, is a

1 member of the board of medical examiners under [section 28].

2 (6) Beginning [the applicability date of this section],
3 every patient, every patient's representative, and every
4 health care provider is subject to and bound by [sections 1
5 through 32].

6 - END -

**** Bill No. ****

Introduced By *****

By Request of the *****

A Bill for an Act entitled: "An Act providing that an insurer of medical malpractice liability need not pay and may not be ordered by a court to pay any type of damages, including but not limited to medical expenses and lost wages, prior to a final settlement or a judgment when liability for the act or omission and liability for the damages are reasonably clear; amending sections 33-18-201 and 33-18-242, MCA; and providing an applicability date."

Be it enacted by the Legislature of the State of Montana:

Section 1. Section 33-18-201, MCA, is amended to read:

"33-18-201. Unfair claim settlement practices prohibited. (1) No person may, with such frequency as to indicate a general business practice, do any of the following:

~~(1)~~(a) misrepresent pertinent facts or insurance policy provisions relating to coverages at issue;

~~(2)~~(b) fail to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

~~(3)~~(c) fail to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

~~(4)~~(d) subject to subsection (2), refuse to pay claims

1 without conducting a reasonable investigation based upon all
2 available information;

3 ~~(5)~~(e) fail to affirm or deny coverage of claims within
4 a reasonable time after proof of loss statements have been
5 completed;

6 ~~(6)~~(f) neglect to attempt in good faith to effectuate
7 prompt, fair, and equitable settlements of claims in which
8 liability has become reasonably clear;

9 ~~(7)~~(g) compel insureds to institute litigation to
10 recover amounts due under an insurance policy by offering
11 substantially less than the amounts ultimately recovered in
12 actions brought by such insureds;

13 ~~(8)~~(h) attempt to settle a claim for less than the
14 amount to which a reasonable ~~man~~ person would have believed
15 ~~he~~ the person was entitled by reference to written or printed
16 advertising material accompanying or made part of an
17 application;

18 ~~(9)~~(i) attempt to settle claims on the basis of an
19 application which was altered without notice to or knowledge
20 or consent of the insured;

21 ~~(10)~~(j) make claims payments to insureds or
22 beneficiaries not accompanied by statements setting forth the
23 coverage under which the payments are being made;

24 ~~(11)~~(k) make known to insureds or claimants a policy of
25 appealing from arbitration awards in favor of insureds or
26 claimants for the purpose of compelling them to accept
27 settlements or compromises less than the amount awarded in
28 arbitration;

29 ~~(12)~~(l) delay the investigation or payment of claims by

requiring an insured, claimant, or physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms; when both of ~~which~~ submissions contain substantially the same information;

~~(13)~~(m) subject to subsection (2), fail to promptly settle claims, if liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

~~(14)~~(n) fail to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(2) An insurer of medical malpractice liability need not pay and may not be ordered by a court to pay any type of damages, including but not limited to medical expenses and lost wages, prior to a final settlement or a judgment when the insurer's liability for the act or omission and liability for the damages are reasonably clear."

{ Internal References to 33-18-201: x
7-34-103 27-1-220 33-1-102 33-18-232
33-18-232 33-18-242 33-18-242 33-18-242
33-28-207 }

Section 2. Section 33-18-242, MCA, is amended to read:

"33-18-242. Independent cause of action -- burden of proof. (1) An insured or a third-party claimant has an independent cause of action against an insurer for actual damages caused by the insurer's violation of subsection ~~(1)~~,

1 ~~(4), (5), (6), (9), or (13)~~ (1)(a), (1)(d), (1)(e), (1)(f),
2 (1)(i), or (1)(m) of 33-18-201.

3 (2) In an action under this section, a plaintiff is not
4 required to prove that the violations were of such frequency
5 as to indicate a general business practice.

6 (3) An insured who has suffered damages as a result of
7 the handling of an insurance claim may bring an action
8 against the insurer for breach of the insurance contract, for
9 fraud, or pursuant to this section, but not under any other
10 theory or cause of action. An insured may not bring an action
11 for bad faith in connection with the handling of an insurance
12 claim.

13 (4) In an action under this section, the court or jury
14 may award such damages as were proximately caused by the
15 violation of subsection ~~(1), (4), (5), (6), (9), or (13)~~
16 (1)(a), (1)(d), (1)(e), (1)(f), (1)(i), or (1)(m) of
17 33-18-201. Exemplary damages may also be assessed in
18 accordance with 27-1-221.

19 (5) An insurer may not be held liable under this
20 section if the insurer had a reasonable basis in law or in
21 fact for contesting the claim or the amount of the claim,
22 whichever is in issue.

23 (6) (a) An insured may file an action under this
24 section, together with any other cause of action the insured
25 has against the insurer. Actions may be bifurcated for trial
26 where justice so requires.

27 (b) A third-party claimant may not file an action under
28 this section until after the underlying claim has been
29 settled or a judgment entered in favor of the claimant on the

underlying claim.

(7) The period prescribed for commencement of an action under this section is:

(a) for an insured, within 2 years from the date of the violation of 33-18-201; and

(b) for a third-party claimant, within 1 year from the date of the settlement of or the entry of judgment on the underlying claim.

(8) As used in this section, an insurer includes a person, firm, or corporation utilizing self-insurance to pay claims made against them."

{ Internal References to 33-18-242: x
7-34-103 33-1-102 33-1-1205 33-18-232
33-18-232 33-28-207 33-35-306 }

NEW SECTION. **Section 3. Applicability.** [This act] applies to medical malpractice claims that arise after [the effective date of this act].

- END -

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E-Mail: jmacmaster@state.mt.us }

**** Bill No. ****

Introduced By *****

By Request of the *****

1 A Bill for an Act entitled: "An Act revising the medical
2 malpractice legal panel act; requiring a claimant before the
3 panel to pay half of the costs of the panel; increasing the
4 maximum time in which a claim must be heard; requiring a
5 record of the panel hearing; providing that the record,
6 documentary evidence that is submitted, and panel decision
7 are admissible in an action subsequently filed in a court;
8 amending sections 27-6-204, 27-6-206, 27-6-207, 27-6-501, 27-
9 6-502, 27-6-703, and 27-6-704, MCA; and providing an
10 applicability date."
11

12 Be it enacted by the Legislature of the State of Montana:
13

14 **Section 1.** Section 27-6-204, MCA, is amended to read:

15 **"27-6-204. Authority to adopt rules.** The director, in
16 consultation with the state bar of Montana and subject to
17 approval of the supreme court, is authorized to adopt and
18 publish rules of procedure necessary to implement and carry
19 out the duties of the medical review panel. ~~No rules may be~~
20 ~~adopted, however, which require a party to make a monetary~~
21 ~~payment as a condition to bringing a malpractice claim before~~
22 ~~the medical review panel."~~

23 {Internal References to 27-6-204: None.} *
24

1 Section 2. Section 27-6-206, MCA, is amended to read:

2 "27-6-206. Funding. (1) There is a pretrial review fund
3 to be administered by the director exclusively for the
4 purposes stated in this chapter. The fund and any income from
5 it must be held in trust, deposited in an account, and
6 invested and reinvested by the director with the prior
7 approval of the director of the Montana medical association.
8 The fund may not become a part of or revert to the general
9 fund of this state but is open to auditing by the legislative
10 auditor.

11 (2) (a) To create the fund, a surcharge or assessment
12 must be levied on all health care providers and a fee must be
13 levied on each claimant who submits a case to the panel. The
14 amount of the health care provider assessment must be set
15 annually by the director and must be apportioned among
16 physicians, dentists, podiatrists, hospitals, and other
17 health care providers by group. Except as provided in
18 subsection (2)(c), for the group of all physicians, the group
19 of all dentists, the group of all podiatrists, the group of
20 all hospitals, and the group of all other health care
21 facilities, the amount of the assessment must be
22 proportionate to the respective percentage of total health
23 care providers brought before the panel that each group
24 constitutes. The total number and group of health care
25 providers brought before the panel must be determined from
26 the annual report of the panel for the years preceding the
27 year of assessment.

28 (b) Except as provided in subsection (2)(c), the amount

1 of the assessment for the group of all:

2 (i) hospitals must be proportionately assessed against
3 each hospital on the basis of each hospital's total number of
4 licensed hospital beds, whether used or not, as reflected in
5 the most recent compilation of the department of public
6 health and human services;

7 (ii) physicians must be equally assessed against all
8 physicians;

9 (iii) dentists must be equally assessed against all
10 dentists;

11 (iv) podiatrists must be equally assessed against all
12 podiatrists; and

13 (v) other health care facilities must be equally
14 assessed against all other health care facilities.

15 (c) The annual amount of the assessment levied against
16 each health care provider may not be less than \$15. The total
17 amount levied against all health care providers must be the
18 amount estimated to be needed to finance one-half of the cost
19 of administering this chapter, including panel proceedings,
20 for the assessment year. The fee levied against a claimant
21 must be determined and levied at the end of panel proceedings
22 relating to that claimant and must equal one-half the costs
23 of the panel that heard the claim.

24 (d) Surplus funds, if any, above the amount required
25 for the annual administration of ~~the~~ this chapter must be
26 retained by the director and used to finance the
27 administration of this chapter in succeeding years, in which
28 event the director shall reduce the annual health care

1 provider assessment in subsequent years to not less than \$15
2 for each health care provider, and shall reduce the
3 claimant's fee, commensurate with the proper administration
4 of this chapter.

5 (3) The annual ~~surcharge~~ health care provider assessment
6 must be paid on April 1 of each year.

7 (4) All unpaid health care provider assessments and
8 claimants' fees bear a late charge fee equal to the judgment
9 rate of interest. The late charge fee ~~is part of the annual~~
10 ~~surcharge for a health care provider may be added to the~~
11 health care provider's next annual assessment. The panel may
12 collect the ~~annual surcharge by an action at law~~ an unpaid
13 health care provider assessment or claimant fee by any method
14 allowed by law for the collection of a judgment."

15 { *Internal References to 27-6-206: **
16 *27-6-207* }

17
18 **Section 3.** Section 27-6-207, MCA, is amended to read:

19 "27-6-207. **Panel audits.** (1) The panel must be audited
20 by or at the direction of the legislative auditor in
21 accordance with the powers and duties set forth in 5-13-304
22 and 5-13-309. The audit must include a determination of the
23 adequacy, sufficiency, and reasonableness of the annual
24 health care provider surcharge or assessment and claimant's
25 fee provided for in 27-6-206.

26 (2) A copy of each audit report of the panel must be
27 furnished to the supreme court.

28 (3) The cost of any audit of the panel performed
29 pursuant to this section must be paid by the panel."

{ Internal References to 27-6-207: None. } *

Section 4. Section 27-6-501, MCA, is amended to read:

"27-6-501. Time and place of hearing. (1) A date, time, and place for hearing ~~shall~~ must be fixed by the director subject to subsection (2), and prompt notice ~~thereof shall be~~ of the date, time, and place given to the parties involved, the attorneys, and the members of the panel. ~~In no instance may the date set~~ The date may not be more than ~~120 days~~ 6 months after the transmittal by the director of the application for review unless the panel finds good cause exists for extending the period.

(2) Panel hearings may be held in any county the panel considers necessary or advisable. The county commissioners or other governing authority shall provide, upon request of the director of the panel, suitable facilities for ~~any such~~ the hearing."

{ Internal References to 27-6-501: None. } *

Section 5. Section 27-6-502, MCA, is amended to read:

"27-6-502. Conduct of hearing. (1) At the time set for hearing, the claimant submitting the case for review ~~shall~~ must be present and shall make a brief introduction of ~~his~~ the claimant's case, including a resume of the facts constituting the alleged professional malpractice which ~~he~~ the claimant is prepared to prove. The health care provider against whom the claim is brought and ~~his~~ the health care provider's attorney may be present and may make an

introductory statement of ~~his~~ the health care provider's
case.

(2) Both parties may call witnesses to testify before
the panel, ~~which witnesses shall~~. The witnesses must be
sworn. Medical texts, journals, studies, and other
documentary evidence relied upon by either party may be
offered and admitted if relevant. Written statements of facts
by treating health care providers may be reviewed.

(3) The hearing will must be informal, ~~and no official~~
~~transcript may be made~~. The panel must keep a recording of
the hearing by electronic device or have stenographic notes
taken by a court reporter."

{Internal References to 27-6-502: None.} *

Section 6. Section 27-6-703, MCA, is amended to read:

"27-6-703. Records of proceedings -- confidentiality.

The director shall maintain records of all proceedings before
the panel, which must include the nature of the act or
omissions complained of, ~~a brief summary of the evidence~~
~~expressed~~ the record of the hearing proceedings required by
27-6-502, documentary evidence admitted as provided in 27-6-
502, the decision of the panel, and any majority or
dissenting opinions filed. Any Unless a court action is
subsequently filed on the claim, records which may identify
any party to the proceedings may not be made public and are
not subject to subpoena but are to be used solely for the
purpose of compiling statistical data and facilitating
ongoing studies of medical malpractice in Montana."

{ Internal References to 27-6-703: None. } *

Section 7. Section 27-6-704, MCA, is amended to read:

"27-6-704. ~~Panel proceedings and decision privileged from disclosure~~ Disclosure in court actions. (1) A panel member may not be called to testify in a proceeding concerning the deliberations, discussions, decisions, and internal proceedings of the panel.

(2)(a) The Subject to subsection (2)(b), the decision and the reasoning and basis for the decision of the panel, the record of the hearing, and the documentary evidence admitted at the hearing, are not admissible as evidence in an action subsequently brought in a court of law.

(b) Anything in the record or documentary evidence must be otherwise admissible under the rules of evidence and statutes relating to evidence."

{ Internal References to 27-6-704: None. } *

NEW SECTION. Section 8. {standard} Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. Section 9. Applicability. [This act] applies to causes of action that arise after [the effective date of this act].

1 - END -

2 {Name : John MacMaster
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4 Agency: Legislative Services Division
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6 E-Mail: jmacmaster@state.mt.us}

**** Bill No. ****

Introduced By *****

By Request of the *****

1 A Bill for an Act entitled: "An Act providing for
2 qualifications for medical malpractice expert witnesses; and
3 providing an applicability date."
4

5 Be it enacted by the Legislature of the State of Montana:
6

7 NEW SECTION. Section 1. Medical malpractice expert
8 witness qualifications. (1) A person may not testify as an
9 expert witness on issues relating to negligence and standards
10 of care and practice in an action on a malpractice claim, as
11 defined in 27-6-103, for or against a health care provider,
12 as defined in 27-6-103, unless the person:

13 (a) is licensed as a health care provider in at least
14 one state and ordinarily treats the diagnosis or condition or
15 provides the type of treatment that is the subject matter of
16 the malpractice claim or is an instructor of students in an
17 accredited health professional school or accredited residency
18 or clinical research program relating to the diagnosis or
19 condition or the type of treatment that is the subject matter
20 of the malpractice claim; and

21 (b) shows by competent evidence that, as a result of
22 education, training, knowledge, and experience in the
23 evaluation, diagnosis, or treatment of the disease or injury
24 that is the subject matter of the malpractice claim against
25 the health care provider, the person is thoroughly familiar

with the standards of care and practice in the same or a similar community as they related to the act or omission that is the subject matter of the malpractice claim on the date of the incident upon which the malpractice claim is based.

(2) If the malpractice claim involves treatment that is recommended or provided by a physician as defined in 37-3-102, a person may not testify as an expert witness with respect to issues of negligence or standards of care and practice concerning the treatment unless the person is also a physician.

(3) A person qualified as an expert in one medical specialty or subspecialty is not qualified to testify with respect to a malpractice claim against a health care provider in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity with applicable standards of care and practice in accordance with subsection (1)(b), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are substantially similar

NEW SECTION. **Section 2. Applicability.** [This act] applies to causes of action that arise after [the effective date of this act].

- END -

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Appendix C

List and Rankings of Medical Liability Insurance Alternatives
Considered by the SJR 32 Subcommittee on Medical Liability Insurance

At the January 15, 2004, meeting of the SJR 32 Subcommittee on Medical Liability Insurance, the members asked staff to prepare a survey and compile the results for future consideration. The survey forms were distributed to the Subcommittee's eight members on February 18, 2004, and the completed survey forms were collected through March 12, 2004. The results of the survey are shown in Table 1, below, and Table 2, on the following page. Of note, some members provided a response to all of the questions, others did not. Therefore, the totals of the "yes" and "no" columns do not always equal 8.

Appendix C — Table 1

RESULTS OF THE "LIST OF OPTIONS" SURVEY
 CONDUCTED FEBRUARY 18 - MARCH 12, 2004
 SJR 32 SUBCOMMITTEE ON MEDICAL LIABILITY INSURANCE
 (OPTIONS WITH MORE THAN 50% IN FAVOR)

Option No	Description	Yes	No	Percentage of
				Members Favoring Further Examination
25	Wisconsin alternative solution	8	0	100%
7	Arbitration	7	1	88%
13	Ostensible agency	7	1	88%
21 a	Arbitration: What can the stakeholders do?	6	1	86%
21 b	Pooling risks: What can the stakeholders do?	6	1	86%
21 c	Quality control: What can the stakeholders do?	5	1	83%
5	Advance payments	6	2	75%
6	Common law third party bad faith	6	2	75%
8	Captain of the ship doctrine	6	2	75%
16	(Limit the) discoverability of quality initiatives	6	2	75%
22	Medicaid reimbursement (increase)	6	2	75%
10	Informed consent	5	2	71%
19	Market/national forces	5	2	71%
20	What can the Legislature do?	5	2	71%
21 d	Fight (rather than settle) meritless cases	5	2	71%
3	Loss of chance doctrine	5	3	62%
4	Offset personal consumption expenses	5	3	62%
11	Strengthen Montana Medical Legal Panel	5	3	62%
23	Get claims settled faster	5	3	62%
41	State-run, stop-gap liability coverage	5	3	62%
43	State subsidies to providers	5	3	62%
46	Insurance reform: California's Proposition 103	5	3	62%
50	Institute experience rating	5	3	62%
51	Spread the risk more broadly	5	3	62%
24	Insurance reform	4	3	57%
48	Require risk prevention	4	3	57%

Appendix C — Table 2

RESULTS OF THE "LIST OF OPTIONS" SURVEY
 CONDUCTED FEBRUARY 18 - MARCH 12, 2004
 SJR 32 SUBCOMMITTEE ON MEDICAL LIABILITY INSURANCE
 (OPTIONS WITH 50% OR LESS IN FAVOR)

Option No	Description	Percentage of Members Favoring Further Examination		
		Yes	No	
9	Independent medical exam	4	4	50%
14	Hedonic loss (limit)	4	4	50%
15	Certificate of merit for expert witness	4	4	50%
17	Limit frivolous lawsuits	4	4	50%
31	Pretrial screening: Title 27, chapter 6, MCA	4	4	50%
36	Variability of jury awards	4	4	50%
37	Alternative Dispute Resolution	4	4	50%
39	Selective no-fault liability	4	4	50%
42	State patient compensation programs	4	4	50%
44	Joint Underwriting Association	4	4	50%
40	Clinical practice guidelines	3	4	43%
2	Attorney fees (limit)	3	5	38%
12	Revise "good Samaritan" law	3	5	38%
29	Joint and several liability: 27-1-703, et seq., MCA	3	5	38%
34	Specialized "medical malpractice" courts	3	5	38%
35	Jury education	3	5	38%
47	Reform medical board governance	3	5	38%
18	Unless Legislature does something radical, options are limited	2	4	33%
26	Statute of limitations: 27-2-205, MCA	2	5	29%
1	Mandatory collateral source	2	6	25%
38	Enterprise Liability	2	6	25%
45	State-funded indemnity for specific services	2	6	25%
28	Collateral source rule: 27-1-308, MCA	1	3	25%
49	Require periodic recertification of doctors, i.e. exam/audit	1	6	14%
30	Periodic payments: 25-9-412, MCA	1	7	12%
32	Contributory or comparative negligence: 27-1-702, MCA	1	7	12%
27	Limits on noneconomic damages: 25-9-411, MCA	0	8	0%
33	Prejudgment interest: 27-1-210, MCA	0	8	0%

Appendix D

State Medical Liability Laws Table

Compiled by the National Conference of State Legislatures

Denver, Colorado

2003



NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

STATE MEDICAL LIABILITY LAWS TABLE

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Alabama	\$6.5.482 (1975, 1993) 2 years from date of injury or 6 months from reasonable discovery; no suit may be brought 4 years after date of injury; minors under 4 by age 8 if statute would have otherwise expired by that time	\$6.5.544 (1987) \$400,000 limit on non-economic damages, including punitive damages; \$6.5.547 \$1 million limit on total damages (court decision upheld cap only in wrongful death actions); \$6-11-21 \$250,000 cap on punitive damages except for wrongful death and suits alleging patterns of intentional wrongful conduct, actual malice or defamation ²	\$6.5.545 (1987) Discretionary offset; allows the jury to be informed if medical bills and/or lost wages have been paid by a third party	\$6.5.543 (1987) Mandatory periodic payment of future damages in medical injury cases in excess of \$150,000		\$6.5.548(1997) Expert witness must be certified in same specialty as defendant and must have practiced within previous year		Alabama Supreme Court upheld constitutionality of statute of limitations in <i>Barlow v. Humana</i> , (1986); <i>Tucker v. Nichols</i> (1983); <i>Reese v. Fite Memorial Hospital</i> , (1981); non-economic damages portion of damage awards limitations ruled unconstitutional in <i>Moore v. Infirmary Assoc.</i> (1991); cap on total damages, excluding wrongful death, overturned in <i>Ray v. Anesthesia Assoc.</i> (1995); punitive damages cap ruled unconstitutional in <i>Henderson v. Alabama Power Co.</i> (1993); non-medical malpractice statute similar to collateral source rule struck down in <i>American Legion Post No. 57 v. Leahy</i> (1996)

¹ Expert witness rules commonly are established by case history. Summary chart includes only rules established by statute.

² Underline indicates statutes overturned by decisions of court (see Case History for specific citation) or was repealed by act of the legislature.

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Alaska	§09.10.070 (1962) 2 years from discovery of injury; tolled by disability	§09.17.010 (1997) For injuries after Aug. 7, 1997, non-economic damages cap greater of \$400,000 or plaintiff's life expectancy, in years, multiplied by \$8,000; for severe injury, the greater of \$1 million and life expectancy in years times \$25,000; §9.17.020 (1997) punitive damages cap greater of \$500,000 or 3 times compensatory damages, whichever is greater, unless malicious action, then greater of \$7 million or 4 times compensatory damages; 50% of punitive damages to state fund	§09.55.548 (1992) Mandatory offset of collateral sources, except federal program benefits requiring subrogation and life insurance	§09.55.548 (1976) Discretionary periodic payment of future damages for medical treatment, care or custody, loss of future earnings, or loss of bodily function	§09.55.536 (1976) Mandatory submission of claims to pretrial screening panel, unless court waives this requirement or parties agree to arbitrate; results of screening admissible at later trial	§09.20.185 (1997) Expert witnesses must be licensed and trained in the defendant's discipline and certified by a board recognized by the state		Alaska Supreme Court upheld constitutionality of pretrial screening panels in <i>Keyes v. Humana Hospital Alaska, Inc.</i> , (1988)
Arizona	§12.502, 542 (1971, 1984) 2 years from injury or death; foreign object or intentional fraud: 1 year from discovery; minor or unsound mind: statute begins upon removal		§12.565 (1976, 1984) Discretionary offset; evidence of collateral sources of payment for economic damages admissible at trial	§12.582 May elect for periodic payments made pursuant to court rule; claim for future damages is effective unless objecting party shows trial or arbitration should not be conducted			\$12.568 (1976) Upon request by a party, the court will review the reasonableness for each party's attorney fees	Arizona Supreme Court upheld constitutionality of collateral source rule and mandatory pretrial screening panel requirement in <i>Eastin v. Broomfield</i> (1977); ² periodic payments statute ruled unconstitutional in <i>Smith v. Myers</i> (1994)
Arkansas	§16.114.203 (1979, 1991) 2 years from the date of injury; foreign objects: 1 year from discovery; minors: before age 9, until age 11; plaintiff must bring suit within 1 year from date of removal of disability			§16.114.208 (1979) Discretionary periodic payment of damages over \$100,000; upon death of claimant, court may deduct future pain and suffering and care expenses		§16.114.207 (1979) Testimony by experts whose compensation depends upon outcome of suit prohibited		

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
California	Civ. Proc. §340.5 (1975) 3 years after injury or 1 year after discovery, whichever is first; in no even more than 3 years after injury, unless caused by fraud, concealment, or a foreign object; minor under age 6: 3 years or before age 8, whichever is longer; tolled for foreign body cases until reasonable discovery	Civ. §3333.2 (1975) \$250,000 limit for non-economic damages	Civ. §3333.1 (1975) Discretionary offset; evidence of collateral sources may be introduced at trial	Civ. Proc. §667.7 (1975) Mandatory periodic payment of future damages award exceeding \$50,000, upon request of party; payments to continue after death of plaintiff to parties to whom judgement creditor owed a duty of support			Bus. & Prof. §6146 (1975, 1987) Sliding scale fees may not exceed 40% of the \$50,000, 1/3 of the next \$50,000, 25% of the next \$500,000, and 15% of damages exceeding \$600,000	California Supreme Court upheld constitutionality of damage awards limits and collateral source rules in <i>Fein v. Permanente Medical Group</i> (1985); periodic payment of damage awards upheld in <i>American Bank and Trust Co. v. Community Hospital of Los Gatos</i> . <i>Saratoga, Inc</i> (1984); attorney fees statute upheld in <i>Roa v. Lodi Medical Group, Inc</i> (1985); additional attorneys' fees provisions rejected by voters in 1996
Colorado	§13.80.102(5) (1988) 2 years from date of accrual; in no event more than 3 years from act; foreign objects: 2 years from discovery; minors under age 6 must bring claim before age 8	§13.21.302 (1988) \$1million limit for damages against a hospital or physician; non-economic damages limited to \$250,000; court may increase limit in certain situations; §13.21.203 (1989) permissible recovery for wrongful death limited to \$250,000; §13.64.302.5(5) (1990) no punitive damages against a physician for adverse outcome of prescription, medically prescribed (1991) or experimental drugs (1991) where FDA protocol was followed; §13-21-102 (1990) punitive damages may not exceed actual damage award; court may increase punitive damages to 3 times in certain situations	§§13.21.111.6 (1986) Mandatory offset for sources not contracted by and paid for by the claimant	§13.64.203 (1988) Mandatory periodic payment of future damage awards exceeding \$150,000	§13.22.402; §13.22.311, 401-409 (1988) Mandatory screening for claims of \$50,000 or less by "arbitration panel"; findings of panel not admissible at trial; court may require mediation of medical injury claims	§13.64.401 Expert witness must be licensed physician and substantially familiar with standard of care on date of injury; §13.20.602 (1988) claimant must file certificate of review which states that an expert was consulted and is competent to testify		Colorado Supreme Court upheld constitutionality of non-economic damage awards cap in <i>Scholz v. Metropolitan and Pathologists</i>

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Connecticut	§52.584 (1969) 2 years from discovery; no more than 3 years after act; §52.555 (1991) wrongful death: 2 years from death; no more than 5 years from disputed act or omission		§52.225a (1985) Mandatory offset; court reduces award by collateral sources of payment received by plaintiff, but credits plaintiff with any premiums paid	§52.225d (1987) Discretionary periodic payment of all damages in excess of \$200,000; the parties have 60 days to reach payment terms for damages over \$200,000; if no agreement is reached, a lump sum is awarded	§§38a-56, 19f (1977) Voluntary pretrial screening; unanimous findings of panel members admissible at trial	§52.184c(d) (1986) Expert witness must be licensed physician practicing for 5 years before date of injury	§52.251c (1986) Sliding scale fees may not exceed: third of first \$300,00; 25% of next \$300,000; 20% of next \$300,000; 15% of next \$300,000; and 10% of damages exceeding \$1.2 million	
Delaware	§18.6856 (1976) 2 years from injury; 3 years from discovery if latent injury; minor: age 6 or same as adult	§18.6855 (1976) Punitive damages may be awarded only on finding of malicious intent to injure or will or wanton misconduct	§18.6862 (1976) Discretionary offset; evidence of "public collateral sources of payment" may be introduced (evidence of life insurance or private collateral sources of compensation excluded)	§18.6864 (1976) Discretionary periodic payment of future damages in medical injury actions only; compensation for future pain and suffering and future expenses deducted from balance of payments on death of plaintiff	§18.6801-6814 (1976) submission to review panel on demand; negative opinion admissible as prima facie evidence at any subsequent trial; expert witness testimony may be required for panel	§18.6853-6854 (1976) Required to establish deviation from applicable standard of care unless panel found negligence to have caused injury; experts knowledge of similar locality in order to testify	§18.6865 (1976) Sliding scale fees may not exceed: 35% of first \$100,000; 25% of next \$100,000; and 10% of damages exceeding \$200,000	
District of Columbia	§12.301-2 (1995) 3 years from reasonable discovery; wrongful death: 1 year from death							

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Florida	§95.11 (1972, 1980) 2 years from injury or discovery, no more than 4 years from injury; minors: age 8; if fraud, concealment of injury or intentional misrepresentation prevented discovery within 4 year period, 2 year limit from discovery, not to exceed 7 years after the act	\$768.73 (1997) Punitive damages in excess of 3 times economic damages or \$500,000 presumed excessive; §766.207, 209 (1988) where parties agree to binding arbitration, (1) net economic damages for wage loss including, to 80% of wage loss and earning capacity; (2) non-economic damages limited to maximum \$250,000 calculated for capacity to enjoy life; where the plaintiff refuses to arbitrate, non-economic damages may not exceed \$350,000 plus net economic damages including past and future medical expenses and 805 of wage loss and loss of earning capacity; no limits where defendant refuses to arbitrate	\$768.76 (1986) Mandatory offset by court, except for those collateral sources for which there are subrogation rights; §§766.207, 209 (1988) rule extends to binding arbitration cases	\$768.78 (1986) Mandatory periodic payment of future damage award exceeding \$250,000, at the request of a party; defendant may elect to pay lump sum for future economic losses and expenses reduced to present value; §766.207(7)(c) (1988) damages for future economic losses awarded by arbitration payable on periodic basis under 766.202(8)	\$766.106-107 (1985) Court may require submission of claim to an arbitrary panel; result not admissible in a later trial	\$766.102(c) (1988) Expert testimony by licensed physician in same practice or practicing for 5 years before claim filed	Atty. Conduct Reg. 4-1.5(f)(40(b) Separate sliding scales for cases settling before filing an answer or appointing an arbitrator, cases settling before or after going to trial, and which liability is admitted and only damages contested; 5 % extra for cases appealed	Voluntary binding arbitration caps found unconstitutional in <i>Univ. of Miami School of Medicine v. Echarte</i> ; 1975 <i>Medicine v. Echarte</i> ; 1975 statute, without the subrogation exception, upheld in <i>Pinillos v. Cedars of Lebanon Hospital Corp.</i> (1981) and <i>Smith v. Department of Insurance</i> (Fla. 1987); earlier pretrial screening panel provision found unconstitutional in <i>Aldana v. Holub</i> (1980)
Georgia	§9.3.71-73, 9.63 (1992) 2 years from injury or death; in no event longer than 5 years from act or death; foreign object: 1 year from discovery; minors: age 7 and, and in no event later than age 10; agreement by parties to arbitrated tolls statute	§51.12.5.1 (1992) \$250,000 cap on punitive damages, unless demonstrated intent to harm	§51.12.1 (1987) Collateral sources evidence admissible to jury		\$9.9.61-63 (1997) Voluntary arbitration subject to court review; binding if prior agreement to make it so	\$9.11.9.1 (1998) Complaint must generally contain an affidavit of an expert stating that the facts justify a claim of negligence		Georgia Supreme Court upheld as constitutional statute of repose in <i>Craven v. Lowndes County Hospital Authority</i> (1993); collateral source rule found unconstitutional in <i>Georgia Power Co. v. Falagan, et al</i> (1991); <i>Denitor v. Con-Way Southern Express, Inc</i> (1991)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Hawaii	\$657.7.3, 671.18 (1973, 1986) 2 years from discovery, not to exceed 6 years from act; minors: age 10 or within 6 years, whichever is longer; arbitration tolls statute until 60 days after the panel's decision is delivered but for no more than 18 months	\$663.8.5, 8.7 (1986) \$375,000 cap for pain and suffering damages; excludes mental anguish, disfigurement, loss of enjoyment of life, and loss of consortium			\$601-20 (1986) Mandatory nonbonding arbitration for all cases involving \$150,000 or less; \$671.11-20 (1976) mandatory submission of medical injury claim to medical claim conciliation panel; results not admissible at trial		\$607.15.5 (1986) Attorney fees must be approved by the court	
Idaho	\$5.219 (1971) 2 years from injury; foreign object: 1 year from reasonable discovery or 2 years from injury, whichever is later	\$6.1603 (1987) \$400,000 cap on non-economic damages in any tort action, unless personal injury cause by "willful or reckless misconduct" or felony; cap adjusted annually according to the state's adjustment of the average annual wage; \$6.1606 (1990) removed 1992 Sunset	\$6.1606 (1990) Mandatory offset of collateral sources except for federal benefits, life insurance and subrogation rights	\$6.1602 (1987) Discretionary periodic payment of future damage awards exceeding \$100,000, excluding cases involving intentional tort, gross negligence, or extreme deviation from standards unless agreed to by claimant	\$6.1001-1011 (1976) mandatory submission of claim to hearing panel; results not admissible at trial	\$6.1012 (1990); Claimant must prove negligence by direct expert testimony; \$6.1013 (1976) Expert witness must have knowledge of community standards		Idaho Supreme Court upheld constitutionality of statute of limitations in <i>Homes v. IWASA</i> (1983); earlier damage awards limit applying only to medical liability overturned in <i>Jones v. State Board of Medicine</i> (1976) cert denied (1977)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Illinois	\$735.5/13.212 (1992) 2 years from discovery but not more than 4 years from act; statute tolled for disability (where plaintiff is insane, mentally ill or imprisoned); minors: 8 years after act but not after age 22; \$740.180/2 (1995) wrongful death: 2 years from death, if statute of limitation on personal injury still valid at time of death	\$735.5/2.1115.1 (1997) \$500,000 cap on non-economic damages; \$735.5/1115 (1985) punitive damages not recoverable in medical malpractice cases	\$735.5/2.120 5 (1992) Claimant may apply within 30 days of judgment for 50% reduction of collateral payments for lost wages or disability benefits; 100% of medical benefits (with exceptions), but not more than 50% of total award	\$735.5/2.1705-6 (1985) Voluntary or discretionary periodic payment of future damages awards over \$250,000		\$735.5-8 Plaintiff required to provide affidavit stating that expert has been consulted	\$110.2.1114 (1985) Sliding scale fees may not exceed third of first \$150,000; 25% of next \$850,000 and 20% of damages exceeding \$1 million; \$735.5/2.1114 (1992) attorney may apply to the court for additional compensation under certain circumstance	Illinois Supreme Court upheld constitutionality of statute of limitations in <i>Anderson v. Wagner</i> (1979), reversing <i>Woodward v. Burnham City Hospital</i> (1987); non-economic damage award cap struck down in <i>Best v. Taylor Machine Works</i> (1997); similar 1975 statute overturned in <i>Wright v. Central Du Page Hospital Association</i> (1976); pretrial screening panel provision struck down and periodic payment of damage awards upheld in <i>Bernier v. Burris</i> (1986)
Indiana	\$34-18-7-1 (1998) 2 years from act, omission, or neglect; minors: under age 6 until age 8; applies regardless of minority or other disability	\$34-18-18-1 (1998) For acts prior to 1990, \$100,000 cap from a single provider and \$500,000 cap from all providers and Patient Compensation Fund (PCF); as of 1990, \$750,000 cap for all providers and PCF; as of July 1999, \$250,000 limit for each provider and a \$1,250,000 for all providers and PCF; only 1 recovery per single injury; no damage caps in cases not brought against qualified providers	\$34.44.1.2 (1998) Collateral sources except life insurance, insurance payments made directly to plaintiff, plaintiff's family or state/federal benefits paid before trail admissible at trail	\$34.18.15.1 (1985) Discretionary periodic payment	\$34.18.8.4-6 (1975) mandatory submission of claim, unless parties agree otherwise, of claims more than \$15,000; panel determination is admissible at any later trail	\$34.18.10.23 Medical review panel's testimony may qualify as expert testimony to establish prima facie	\$16.9(5).5.1 (1975) Plaintiff's attorney fees may not exceed 15% of any award that is made from PCF (covers portion of an award that exceeds \$100,000)	Indiana Supreme Court upheld constitutionality of statute of limitation, but established an exception where medical condition prevented discovery in <i>Martin v. Richey</i> (1999); original 1975 pretrial screening panel, limits on damage awards, and statute of limitation provisions upheld as constitutional in <i>Johnson v. St. Vincent Hospital</i> (1980); <i>St. Anthony Medical v. Smith</i> (1992); <i>Bova v. J.H. Roig, M.D.</i> (1992)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Iowa	§614.1(9) (1997) 2 years from reasonable discovery but not more than 6 years from injury unless foreign object; minors under age 8: until age 10 or same as adults, whichever is later; mentally ill: extends to 1 year from removal of disability		§147.136 (1975) Mandatory offset of collateral sources	§668.3 (1987) Discretionary court-ordered periodic payment of future damages	§679A.1 (1981) Written arbitration agreement valid and irrevocable	§147.139 Qualifications of the expert must relate directly to problem at issue	§147.138 (1975) Court may review fees in any personal injury or wrongful death action against specified health care providers or hospitals	Eight Circuit upheld constitutionality of original 1945 statute of limitation in <i>Fitz v. Dolyak</i> (1983)
Kansas	§60.513.7(c) (1965) 2 years from act or reasonable discovery by not more than 4 years after injury; incompetent: 1 year from removal, but no more than 8 years from act	§60.19a02 (1988) \$250,000 cap on non-economic damages recoverable by each party from all defendants; §60.3702 (1994) punitive damages limited to lesser of defendant's highest gross income for prior 5 years or \$5 million; if profitability of misconduct exceeds cap, court may award 1.5 times profit instead; judge determines punitive damage; punitive damages unavailable in wrongful death cases	§60.3801-3807 (1992) <u>Collateral sources admitted where plaintiff claims more in damages</u>		§65.4901 (1976) Voluntary submission to medical screening panel upon request of party; §60.3501-3509 (1987) decisions admissible at any subsequent trial	§60.3412 50% of the expert's professional time over preceding 2 years must have been devoted to clinical practice		Kansas Supreme Court upheld constitutionality of statute of limitations in <i>Stephens v. Snyder Clinic Association</i> (1981); noneconomic damages cap ruled constitutional in <i>Samsel v. Wheeler Transport Services, Inc.</i> (1990); collateral source rule ruled unconstitutional in <i>Thompson v. KFB Insurance Company</i> (1993), Ks. Sup. Ct; earlier discretionary offset (1985, 1988) that applied only to medical liability actions struck down in <i>Farley v. Engleken</i> (1987); 1965 cap on damage awards and periodic payment provision found unconstitutional in <i>Kansas Malpractice Victims v. Bell</i> (1988)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules	Attorneys' Fees	Case History
Kentucky	§413.140 (1974) 1 year from act or reasonable discovery, but not more than 5 years after act; minor and unsound mind: statute runs when disability lifted		§411.188.3 (1988) <u>Discretionary offset of collateral sources except life insurance</u>		\$417,050 (1984) Written arbitration agreements enforceable and irrevocable			Kentucky Supreme Court ruled unconstitutional 5 year statute of limitation in <i>McCollum v. Sisters of Charity of Nazareth Health Corp.</i> (1990); collateral source rule overturned in <i>O'Bryan v. Hedgespeth</i> (1995)
Louisiana	§9.5628 (1975, 1987) 1 year from act or date of discovery, but no later than 3 years from date of injury; applies regardless of minority or disability; Civ. Code §2315.2 wrongful death: 1 year from death	\$100,000 liability limit for qualified health care providers; punitive damages not recoverable, except in certain situations				§40.122.47 Medical review panel's report considered expert testimony		Appellate Court upheld the constitutionality of statute of limitation in <i>Valentine v. Thomas</i> (1983); Louisiana Supreme Court upheld the constitutionality of limits on damage awards in <i>Williams v. Kushner, slip. Op.</i> (1989), <i>Butler v. Flint Goodrich Hospital of Dillard University</i> , (1992); 1976 pretrial screening panel provision upheld in <i>Everett v. Goldman</i> (1978)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Maine	§24.2902 ('1977) 3 years from cause of action; 6 years after accrual for minors or within 3 years of minority, whichever is first; foreign objects: accrue from reasonable discovery; incompetence: accrue upon lifting of disability	§18A.2.804 (1999, 1990) For wrongful death cases, non-economic damages limited to \$150,000 and punitive damages limited to \$75,000	§24.2906 (1990) Mandatory offset of collateral sources that have not exercised subrogation rights within 10 days after a verdict for the plaintiff	§24.2951 (1985) Mandatory periodic payments of future economic damages exceeding \$250,000 at the request of a party	§24.2951-59 (1990, 1986-1989) Mandatory submission of medical injury claims to a "pre-litigation screening and mediation panel" except where all parties have agreed to bypass; any findings unanimous and unfavorable to the claimant as to both negligence and causation are admissible at any subsequent trial; for claims after January 1, 1991, panel's discovery is deemed court discovery at any subsequent trial		§24.2961 (1985-1987) Sliding scale fees may not exceed: third of first \$100,000; 25% of next \$200,000 and 20% of damages that exceed \$200,000; for purpose of rule, future damages are to be reduced to lump-sum value	

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Maryland	Cts. & Jud. Proc. §5.109 (1975) 5 years from act or 3 years from discovery, whichever is earlier; minors: statute begins at age 11; excepts reproductive system damage or foreign object injury; Cts. & Jud. Proc. §3.904 (1995) wrongful death: must be filed with 3 years of death	Cts. & Jud. Proc. §11.108 (1986, 1994) In any action for damages for personal injury accruing after October 1, 1994, \$500,000 cap on non-economic damages; \$620,000 cap in 2002 due to \$15,000 increase every October 1 beginning in 1994; separate cap for each "direct victim"; wrongful death cases may not exceed 150% of cap		Cts. & Jud. Proc. §11.109 (1986) Discretionary periodic payment of future economic damages	Cts. & Jud. §3.2A.03-06 (1995) Discretionary submission of claims to a "health claims arbitration panel"; panel's decision on fault is "presumed to be correct" and its award is admissible as evidence at any subsequent trial; rejecting party liable to other for costs if verdict less favorable than findings	§3.2A.04 (1997) Within 90 days of filing, claimant must file certificate of expert consultation	Cts. & Jud. Proc. §3.2A.07 (1976) Court or pretrial screening panel will review disputed fees in medical injury actions	Damage award cap on non-economic damages ruled constitutional in <i>Murphy v. Edmonds</i> , 325 (1992)
Massachusetts	§§231.60D; 260.4, 7 (1986) 3 years from date of injury, but not more than 7 years from injury unless foreign object; minors: before age 6 until age 9; tolled for disability	§231.60H (1986) \$500,000 cap for non-economic damages unless jury determines that there is "a substantial or permanent loss or impairment of a bodily function or substantial disfigurement, or other special circumstances"; if the total amount of general damages from a single occurrence for all plaintiffs exceeds \$500,000, then the amount of such damages recoverable by each plaintiff will be reduced to a percentage of \$500,000 proportionate to that plaintiff's share of the total amount	§231.60G (1986) Mandatory offset determined by the court		§231.608 (1975) Mandatory submission or medical injury claims to a "medical malpractice tribunal", decision admissible at any subsequent trial; if tribunal finds against claimant, claimant must post \$6,000 (or greater) bond for defendants costs if unsuccessful		§231.601 (1986) Sliding scale fees may not exceed: 40% of first \$150,000, 33.33% of next \$150,000, 30% of next \$200,000 and 25% of damages that exceed \$500,000; further limits if claimants recovery insufficient to pay medical expenses	Massachusetts Supreme Judicial Court upheld the constitutionality of pretrial screening panel requirement in <i>Paro v. Longwood Hospital</i> (1977)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Michigan	600.5838a, 5851(1846-1986) 2 years from injury or 6 months from reasonable discoverability, whichever is later, not to exceed 6 years; 6 years tolled for fraud or reproductive systems; disabled plaintiff: 1 year after injury except in cases of reproductive injury; foreign object: 6 months; minors under age 8: 6 years from date of occurrence or age 10, whichever is later (if action brought after 10th birthday, must be within the 6 year limit)	\$600.1483 (1986) After April 1, 1994, \$280,000 cap on noneconomic damages, \$500,000 cap for non-economic damages applies to certain other circumstance; caps adjusted annually for inflation; in 2002, caps are \$349,700 and \$624,500, respectively	\$600.6303 (1986) Mandatory offset of collateral sources, except life insurance, admissible after a verdict for plaintiff	\$600.5056 (1975) third of a medical malpractice arbitration award, unless parties stipulate awards in excess of \$50,000, to be paid lump sum; \$600.6307 (1986) mandatory periodic payment of future economic damages excluding future medical, other health care costs and collateral source benefits; future non-economic damages reduced to gross percent cash value	\$600.4903, 15, 17, 21 (1987) Mandatory review by medication panel; party rejecting panel's evaluation must pay opposing party's actual cost unless verdict more favorable than panel; \$600.2912g (1975) parties may enter into binding arbitration if total damages claimed are less than \$75,000	\$600.2912 Expert must be a licensed health professional, practice in a similar specialty, be board certified (if required on specialty), during the year preceding action had clinical or academic experience in specialty; certificate of consultation must be filed	Mich. Court Rules 8.121(b) (1981) Maximum contingency fee for a personal injury action is third of the amount recovered	
Minnesota	\$541.07 (1935, 1982) 2 years from injury or termination of treatment; tolled for insanity; infant's claim must be asserted within 7 years from injury or 1 year after age of majority		\$548.36 (1986) Mandatory offset of collateral sources by court if defendant brings in evidence of payments made to plaintiff	\$549.25 (1988) Discretionary periodic payment of future damages in excess of \$100,000		\$145.682 (1989) Claimant must file an affidavit stating that an expert has been consulted		Eighth Circuit has upheld the constitutionality of the statute of limitation in <i>Jewson v. Mayo Clinic</i> (1982)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Mississippi	§15.1.36 (1976) 2 years from act or reasonable discovery, within 7 years after the act; mentally incompetent plaintiffs: 2 years after disability ceases; minors under 6: 2 years after age 6 or death, whichever is first; tolled for insanity	HB2 3rd Extraordinary Session (2002) effective January 1, 2003, \$500 thousand cap on non-economic damages; increases to \$750 thousand on July 1, 2011 and to \$1 million on July 1, 2017; caps are excluded in disfigurement cases or at the judge's discretion; §11-11-3(2) (2002) cases must be brought in the in which the alleged act or omission occurred				§11.1.61 (1990) Expert witness must be licensed physician		
Missouri	§516.105 (1976) 2 years from act; foreign object: 2 years from discovery; in no event longer than 10 years from act or 10 years from minor's 20 th birthday, whichever is later; minor under 8: until age 20	§538.210 (1986) Cap on non-economic damages adjusted annually for inflation; set at \$547,000 in 2002		§538.220 (1986) Mandatory periodic payment of future damages over \$100,000 at the request of the party		§538.225 Affidavit of expert consultation must be filed within 90 of filing of filing action		Supreme Court of Missouri upheld constitutionality of statute of limitation in <i>Ross v. Kansas City Gen. Hosp. & Med. Ct.</i> (1980); statute of limitation from minors 12 and older ruled unconstitutional in <i>Strahler v. St. Luke's Hospital</i> (1986); limit on damage awards upheld in <i>Adams v. Childrens Mercy Hospital</i> (1991); pretrial screening panel provision overturned in <i>State ex rel. Cardinal Glennon Memorial Hospital v. Gearther</i> (1979)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Montana	§27.2.205 (1971) 3 years from injury or discovery; in no event more than 5 years from act; tolled against a potential plaintiff where there has been a failure of disclosure of the act; minors under age 4; 3 years of age 8 or death, whichever occurs first	§25.9.411 (1995) court to impose a \$250,000 limit on any jury award for non-economic damages, for causes of action arising as of Oct. 1, 1995	§27.1.308 (1987) Mandatory offset of collateral sources by judge for awards greater than \$50,000, in bodily injury and death cases	§25.9.4.3 (1995) Mandatory periodic payment at the request of party for awards in excess of \$50,000, as of Oct. 1, 1995; in case of death, payments property of estate	§27.6.701 (1977) Mandatory review by Medical Legal Panel for actions not subject to valid arbitration agreement; panel report neither binding nor admissible at trial			Montana Supreme Court upheld the constitutionality of the pretrial screening panel statute in <i>Linder v. Smith</i> (1981)
Nebraska	§§25.222; 44.2828 (1976, 1996) 2 years from act or 1 year from reasonable discovery, but no more than 10 years after date of act; §25.213 under 21 or mentally disabled; statute runs from removal; §30.810 wrongful death; 2 years from death	§44.2825 (1976, 1986) \$1 million limit on recoveries against health care providers qualifying for state-sponsored excess insurance; fundamental rule of Nebraska law prohibits punitive, vindictive, or exemplary damages	§44.2819 (1976) Non-refundable medical reimbursement benefits credited against judgement, in certain actions		§44.2840-1 (1976) Mandatory review of medical injury claims except where plaintiff affirmatively waives his right to panel hearing; the panel report is admissible in any subsequent trial		§44.976 Court review for reasonableness of attorney fees in cases against health care providers	Nebraska Supreme Court upheld the constitutionality of the limit on damage awards, collateral source rule and pretrial screening panel requirement in <i>Prendergast v. Nelson</i> (1977)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Nevada	\$41A.097 (2002, 1989, 1985) 3 years from injury or 2 years from reasonable discovery, whichever is first; tolled for concealment; minors: statute runs until age 10 for brain damage or birth defects; if sterility alleged, statute runs 2 years after discovery; tolled for insanity or minors ward of state	\$42.005 (1996) \$300,000 or 3 times compensatory damages cap on punitive damages, only awarded for fraud, oppression, or malice; \$41A (2002) \$350,000 cap on non-economic damages with exception for cases of gross malpractice (effective October 1, 2002); limits damages for hospitals and doctors to \$50,000 when treating trauma patients	\$42.020 Damages against health care providers reduced by amount of any prior payment by health care provider to the claimant; mandatory offset	\$42.020 (2002, 1985) Claimant may elect to receive award for future damages in a lump sum reduced to present value, if approved by the court, or as an annuity; or by other means if the defendant posts an adequate bond or other security to ensure full payment	\$41A.003-069 (2002) Abolished the mandatory submission of claims to pretrial screening panel; decision and findings were admissible at subsequent trial; unfavorable ruling made claimant responsible for defendant's court cost, if lost at trial	\$41A.800 (2002) District court must dismiss cases filed without an affidavit to support allegations submitted by a medical expert who practices or has practiced in an area similar to the practice related to the alleged malpractice	\$7.085 (2002, 1995) Court shall require attorneys to personally pay for the cost of expenses that result from their unreasonable conduct in civil litigation	
New Hampshire	\$507.C:4 2 year limit specific to medical malpractice found unconstitutional; \$508:4.8 (1986) 3 years from injury or reasonable discovery; infant or incompetents: 2 years from removal of disability	\$507.C:7 (1977) \$250,000 cap on non-economic damages; \$556:13 \$50,000 cap on wrongful death damages and restricted to immediate or dependent family members; after 1998, wrongful death cap raised to \$150,000 and restricted to surviving spouse; \$507:16 punitive damages prohibited	\$507.C:7(I) (1977) Abolishes collateral source rule in medical malpractice cases	\$524:6.a (1997) Periodic payment awarded at court discretion		\$507.E:2 (1997) Claimants must provide expert testimony to support their claims	\$508:4.e (1986) Fees for actions resulting in settlement or judgement of \$200,000 or more shall be subject to court approval	New Hampshire Supreme Court struck down as unconstitutional the limit on non-economic damage awards, mandatory offset of collateral sources, and earlier provisions for discretionary award of periodic payment of future damages and attorney fees in <i>Carson v. Maurer</i> (1980); \$875,000 limit on non-economic damages found unconstitutional in <i>Brannigan v. Usitalo</i> (1991)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
New Jersey	§2A:14-2, 14-23 (1987) 2 years from accrual of claim or discovery; under 21 or insane: runs upon removal; wrongful death: 2 years from death, 6 months after the death is not computed as part of the time period	§2A:15.5,14(b) (1997) punitive damages cap of \$350,000 or 5 times compensatory damages, whichever is greater	§2A:15.97 (1987) Mandatory offset of collateral sources, excluding workers' compensation or life insurance, admissible at trial and deductible from any verdict for plaintiff		§4:21A.1-8 (1985) Voluntary arbitration of medical claims by written agreement, if claim under \$20,000	§2A:53A.27 Affidavit of consultation of expert must be filed within 60 days of filing action	Court Rules §1:2107 (1976) Sliding scale fees may not exceed third of first \$500,000, 30% of second \$500,000, 25% of third \$500,000 and 20% of fourth \$500,000; 25% cap for a minor or an incompetent plaintiff	New Jersey Supreme Court upheld the constitutionality of a 1978 pretrial screening panel statute in <i>Perna v. Pirozzi</i> (1983)
New Mexico	§41.5.13, 22 (1976) 3 years from injury; minors under 6: until age 9 to file suit; applies to all persons regardless of minority or disability; the statute is tolled upon submission to hearing panel and shall not run until 30 days after panel final decision	§41.5.6-7 (1976) \$600,000 (\$500,000 for acts prior to April 1995) cap to all damages, excluding punitive damages and medical care and related costs; health care providers not liable for any amount over \$100,000; future medical expenses not be awarded as monetary damages		§41.5.7 (1976) Mandatory periodic payment of damages for future medical care up to \$200,000, after which patient's compensation fund must pay	§41.5.14-20 (1976) Mandatory submission of medical injury claims to a hearing panel; panel report is not admissible at any subsequent trial			

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
New York	CVP §214.a (1975) 2 1/2 years from injury or from last treatment where there is continuous treatment for condition giving rise to claim; foreign object: 1 year from discovery; incompetence tolls statute for maximum 10 years		Civ. Prac. §4545 (1981) Mandatory offset of collateral sources made by the court	Civ. Prac. §5031-5039 (1985) Mandatory periodic payment of future damages in excess of \$250,000; parties may agree to lump sum payment; pain and suffering damages paid within a period no longer than 10 years	CPLR §3045 (1991) Defendant may concede liability if plaintiff agrees to arbitrate; if plaintiff refuses, defendant's concession of liability cannot be used for any other purpose; Public Health §4406.2 HMOs can put arbitration clauses in contracts, but not as a condition of joining	§3012.A Certificate of consultation of expert must be filed within 90 days of filing complaint	Jud. §474a (1985) Sliding scale fees may not exceed 30% of first \$250,000, 25% of second \$250,000, 20% of next \$500,000, 15% of next \$250,000 and 10% over \$1.25 million	New York's highest court upheld the constitutionality of a pretrial screening panel statute in <i>Treyball v. Clark</i> (1985)
North Carolina	§1.15 (1979) 3 years from act or 1 year from reasonable discovery, but not more than 4 years after injury; foreign object: 1 year from discovery, but not more than 10 years from last act; wrongful death: 2 years from death	§1D.25 (1995) Punitive damages cap of \$250,000 or 3 times compensatory damages, whichever is greater			§7A.38.1 (1997) Mandatory mediation	§90.21.12 (1990) Expert must testify to community standard of care; §8C.1 Rule 702 expert must be licensed		North Carolina Court of Appeals upheld the constitutionality of the statute of limitations in <i>Robert's v. Durham County Hospital Corp.</i> (N.C. App. 1982)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
North Dakota	§§28.01.18, 25 (1975) 2 years from act or reasonable discovery, but not more than 6 years after act, unless concealed by fraudulent conduct of defendant; minority, tolls statute for 5 years, in no case after 1 year from removal of disability or 6 years total; minors: 12 years	§32.42.02 (1995) \$500,000 cap on non-economic damages; §32.03.2.08 economic damage awards in excess of \$250,000 subject to court review for reasonableness	§32.03.2.06 (1987) Discretionary offset of collateral sources, excluding life insurance, death or retirement benefits or any insurance purchased by recovering party	§32.03.2.09 (1987) Discretionary payment of periodic future economic damages for continuing institutional or custodial care for a period of more than two years; adequacy of payments subject to continuing court review	§32.42.03 (1996) Attorneys must disclose alternative dispute resolutions option; good faith effort to resolve dispute required	§28.01.46 A claimant is required to obtain supportive expert opinion within 3 months of filing complaint		A \$300,000 limit on medical liability awards and an earlier discretionary offset in cases involving \$100,000 or more were struck down as unconstitutional in <i>Ameson v. Olson</i> (N.D. 1978)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Ohio	§2305.11 B(1) (1990) 1 year after reasonable discovery; if plaintiff gives written notice before the 1 year expires, suit may be brought within 180 days of the notice; persons with legal disability must bring suit within 4 years after occurrence; for actions accruing as of Jan. 27, 1997, 6 year statute of repose; minor, unsound mind, or imprisoned: tolled until disability removed; wrongful death: 2 years from death	§2305.54 (1997) as of Jan. 27, 1997, non-economic cap of \$250,000 or 3 times economic damages up to \$500,000, whichever is greater, for more serious loss, \$1 million or \$35,000 times remaining life expectancy; §2315.21 (1997) punitive damages cap or \$100,000 or 3 times compensatory damages, except for defendants that employ more than 25 persons, for whom cap is \$250,000 or 3 times compensatory damages; prohibits punitive damages if defendant already paid amount of cap of punitive damages in another case	§23 (1975) <u>Evidence of collateral sources in medical actions, except for insurance benefits paid for by plaintiff or employer (but including workers' compensation), admissible at trial</u>	§2323.57 (1987) Mandatory periodic payment of future damages over \$200,000 at request of party	§2711.21 (1975, 1987) Voluntary submission of medical injury claims to an "arbitration board" upon agreement of all parties; decision is not admissible at any subsequent trial; prior to 1987 amendment, submission was mandatory and results were admissible	§2743.43 (1975) Expert testimony limited to licensed physician or surgeon who devotes 3/4 time to active clinical practice or teaching; §2305.01.1 claimant must file certificate of consultation with expert		Ohio Supreme Court ruled unconstitutional a comprehensive tort reform package passed in 1997 that included noneconomic damage caps in <i>Ohio Academy of Trial Lawyers v. Sheward</i> (1999); a \$200,000 limit on general damages struck down in <i>Morris v. Savoy</i> (1991); a \$250,000 limit on non-economic damages overturned in <i>Glendon v. Greater Cleveland Regional Transit Authority</i> (1994); the 8th District twice upheld the collateral source rule in <i>Morris, et al. v. Savoy</i> (1991) and <i>Charles William May v. Tandy Corp., et al</i> (1993) and <i>Glendon v. Greater Cleveland Regional Transit Authority</i> (1994); the Court of Appeals of Ohio (11th District) struck down collateral source rule in <i>Schenk v. The Cleveland Electric Illuminating Company</i> (1994); Ohio Supreme Court upheld the 1975 pretrial screening panel statute in <i>Beatty v. Akron City Hospital</i> (1981)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Oklahoma	§§76.18 (1987) 2 years from reasonable discovery; after 3 years from act, recovery limited to past and future actual medical and surgical expenses; §12.96 (1988) minors under 12: 7 years; minors over 12: 1 year after attaining majority but in no event less than 2 years from injury; incompetents: 7 years from injury unless adjudged incompetent, then 1 year after such adjudication, but in no event less than 2 years from injury	§23.9.1 (1998) \$100,000 cap on punitive damages for reckless disregard; punitive damages cap of \$500,000, 2 times compensatory damages, or benefit derived by defendant from his conduct for intentional and malicious acts (waived in certain circumstances); discretionary waiver of damages by court if defendant already paid punitive damages for same action	Discretionary offset of collateral sources				§5.7 (1953) Maximum percentage: fee may not exceed 50% of net judgement	Oklahoma Supreme Court upheld 2-year statute of limitations as constitutional in <i>McCarroll v. Doctors General Hospital</i> (1983); 3 year statute of repose on all damages other than past and future medical and surgical expenses ruled unconstitutional in <i>Wyofford v. Davis</i> (Okla. 1988); earlier limit on damage awards struck down in <i>Reynolds v. Porter</i> (1988)
Oregon	§§12.110; 160 (1988) 2 years from reasonable discovery; but not more than 5 years from act; fraud: 2 years from reasonable discovery; minors or insane: 5 years from accrual or 1 year after disability ceases; wrongful death: 3 years from death or reasonable discovery	§18.540, 560 (1987) \$500,000 cap on non-economic damages (overturned except with regard to wrongful death); §18.550 (1989) no punitive damages awarded against licensed physician unless malice is shown; 60% of punitive damages paid to Criminal Injuries Compensation Account	§18.580 (1987) Discretionary offset after judgement of collateral sources by court, except benefits plaintiff must repay, life insurance, retirement, disability, pension plans or social security				§18.540 Attorneys fees from punitive damages may not exceed half the claimant's 40%	Oregon Supreme Court ruled non-economic damages cap unconstitutional, except in wrongful death suits, in <i>Lakin v. Senco Products, Inc</i> (1999)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Pennsylvania	\$42.5524 (1975) 2 years from injury or reasonable discovery; \$42.5533 minor: 2 years after age of majority	\$40.1301.812.A(g) (1997) Effective Jan. 25, 1997, punitive damages cap of \$100,000 or 2 times compensatory damages; members of Medical Professional Liability Catastrophe Loss Fund, in effect, subject to limited liability			\$40.1301.825A (1975) Mandatory "conciliation hearing", which may be a settlement conference or mediation as the parties prefer	\$1301.821.A Attorney's signature on a complaint certifies that attorney has consulted an expert who will attest to position		Pennsylvania Supreme Court found a statute providing for a mandatory offset of collateral sources in medical liability actions unconstitutional by the in <i>Mattes v. Thompson</i> (1980); earlier mandatory pretrial screening panel struck down in <i>Mattes v. Thompson</i> (1980); panels may exist as long as participation is voluntary and the outcome is not binding; attorney fee limits struck down in <i>Heller v. Frankston</i> (1984)
Rhode Island	§§9.1.14.1; 10.7.2 (1976, 1988) 3 years from injury, death or reasonable discovery; minors and incompetents: 3 years from removal of disability	\$9.1.8 (1997) Punitive damages not recoverable against executor or administrator of an estate; \$9.19.41 (1997) \$100,000 minimum recovery in any wrongful death action	\$9.19.34.1 (1986) Mandatory offset by court in medical liability actions, if evidence is admitted	\$9.21.12-13 (1986) Mandatory conference on periodic payment where judgment exceeds \$150,000		\$9.19.41 (1997) expert must have training/ education to qualify as an expert		Pretrial screening panels were found unconstitutional in <i>Boucher v. Sayeed</i> (1983)
South Carolina	\$15.35.45, 15.3.40 (1977-1988) 3 years from injury or reasonable discovery, but not more than 6 years after act; foreign object: 2 years from discovery; minors: tolled, but no more than 7 years from act or 1 year from majority; tolled for disability, up to 5 years or 1 year after disability ceases							

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
South Dakota	§15.2, 14.1, 221 (1984) 2 years from injury; tolled for fraud or foreign object until end of treatment; tolled for minority for 3 years or until age 8 if under age 6; metal illness; tolls statute up to 5 years; 1 year from removal; wrongful death; 3 years from death	§21.3.11 (1997, 1985) \$500,000 cap on non-economic damages	§21.3.12 (1977) Discretionary offset in medical liability cases, except benefits that have a right if subrogation or were paid for by plaintiff	§21.3A.1-12 (1986-1988) Mandatory periodic payment of future damages in excess of \$200,000 or past and future damages of \$500,000, whichever is less; discretionary at the request of a party	§21.25B.1 (1976) Parties may agree to arbitrate for past and future services; revocable as to future services			The South Dakota Supreme Court rejected the discovery rule in <i>Alberfs v. Giebrink</i> (1980); law reducing statute of limitation for minors ruled unconstitutional in <i>Lyons v. Lederle Laboratories</i> (1989); \$1 million cap on total damages ruled unconstitutional, reviving prior \$500,000 cap on noneconomic damages, in <i>Knowles v. U.S.</i> (1996)
Tennessee	§29.26.116 (1975) 1 year from discovery, but no more than 3 years from act unless foreign object; foreign object: 1 year from discovery; under 18 or unsound mind: 1 year from removal		§29.26.119 (1975) Mandatory offset except for assets purchased by plaintiff or private insurance		§29.5.101 All causes of action may be submitted to the decision of arbitrators except when 1 of the parties is an infant or a person of unsound mind	§29.26.115(b) (1975) Expert witness must be licensed in Tennessee or contiguous state and practice for one year preceding date of injury	§29.26.120 (1975) Plaintiffs attorney fees in a medical injury suit shall not exceed third of all damages awarded	Tennessee Supreme Court upheld the constitutionality of statute of limitation in <i>Harrison v. Schrader</i> (1982)
Texas	Civ. §4590i.10.01 (1977) 2 years from occurrence (discovery); minors under 12; until age 14; otherwise applies to all regardless of minority or disability	Civ. §4509.11.02-04 (1977) approximately \$1.3 million cap on wrongful death damages, adjusted annually for inflation; Civ. Prac. & Rem. §41.008 (1995) punitive damages cap as of Sept. 1, 1995 of 2 times economic damages, plus non-economic damages (not to exceed \$750,000), or \$200,000, whichever is greater, with certain exclusions				§14.01 Expert must have experience relating to complaint; Tex. Rev. Civ. Stat. Ann. 4590I, §13.01 plaintiff must post file on expert w/in 90 days of filing		The Texas Supreme Court struck down limit on damage awards as unconstitutional in <i>Lucas v. United States</i> (1988); limit subsequently found constitutional only in wrongful death cases in <i>Rose v. Doctors Hosp.</i> (1990)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Utah	§78.14.14 (1985) 2 years from discovery but not more than 4 years from act; foreign object or fraud: 1 year from discovery, applies to all persons regardless of minority or disability	§78.14.7.1 (1986) \$250,000 cap on non-economic damages	§78.14.4.5 (1985) Mandatory offset by court except for benefits where subrogation rights exist	§78.14.9(5) (1986) Mandatory periodic payment of future damages that exceed \$100,000, exclusive of attorneys' fees and costs	§78.14.8-16 (1985) Decision of pre-litigation panel may be considered binding arbitration upon written agreement of parties; mandatory submission of claims to panel; panel recommendations not admissible at subsequent trial		§78.14.7(5) (1985) Contingency fee shall not exceed third of award	Utah Supreme Court ruled unconstitutional the minority provision of the statute of limitation in <i>Lee v. Dr. Lynn Craufin</i> ; <i>Griffith v. Dr. J. Dallas Van Wagoner</i> (1993); this reversed an earlier decision in <i>Allen v. International Health Care, Inc.</i> (1981)
Vermont	§12.521, 551 (1977) 3 years from injury or 2 years from reasonable discovery, but no more than 7 years from act, excluding concealment and foreign objects; foreign object: 2 years from discovery; tolled until removal of disability				§12.7002 (1995) Voluntary submission to pretrial arbitration panel; findings subject to appeal unless parties agree to binding arbitration			

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Virginia	\$8.01.229, 243 (1959, 1987) 2 years from injury, but not more than 10 years from act; foreign object or fraud: 1 year from reasonable discovery; infants: 5 years from date of accrual of cause of action; for claims accruing on or after July 1, 1987, minors under 8: age 10; age 8 or older: 2 years after last treatment unless; minors who were 10 or older on or before July 1, 1987: 2 years from that date to bring an action	\$8.01.581.15 (1976-1983) \$1.5 million cap on recovery damages for bodily injury or death, shall increase on July 1, 2000 by \$50,000 and every July 1 after that until 2007 and 2008 when the final increases will be \$75,000 per year; cap applies for each injury, regardless of number of theories or defendants; \$8.01.38.1 (1992) \$350,000 cap on punitive damages		\$8.01.424 Periodic payment of awards permitted, if reviewed by court and secured by bond or insurance	\$8.01.581.2, 8 (1997) Review by pretrial panel by request; findings non-binding; testimony of panel members, except chair, admissible; \$8.01.581.12 (1997) parties permitted to agree in advance of treatment to binding arbitration, with period of patient withdraw	\$8.01.581.20 (1992) Claims must be supported by expert testimony; physicians must have had an active clinical practice in the field about which he will testify within year of incident		Virginia Supreme Court upheld constitutionality of a prior \$750,000 cap on damage awards in <i>Etheridge v. Medical Center Hospitals</i> (1989); pretrial screening panel statute upheld as constitutionality in <i>Speet v. Bauaj</i> (1989)
Washington	\$4.16.350 (1971, 1988) 3 years from injury or 1 year from discovery, whichever is later, but no more than 8 years after act; fraud, concealment or minority toll statute; foreign object: 1 year from discovery; wrongful death: 3 years from death	<u>\$4.56.250 (1986) Noneconomic damages in person injury suit may not exceed an amount determined by multiplying 0.43 by the average annual wage in state and by the life expectancy of the person incurring noneconomic damages; a plaintiff's life expectancy shall not be less than 15 years for the purpose of determining maximum noneconomic damages</u>	\$7.70.080 (1976) Information on collateral sources may be introduced except for insurance purchased by plaintiff or employer	\$4.56.260 (1986) Mandatory periodic payments in personal injury actions of future economic damages of \$100,000 or more			\$7.70.070 (1976) In any medical injury the court shall determine the reasonable expense of each party's attorney fees	Washington Appellate Court upheld constitutionality of statute of limitation on constitutional in <i>Duffy v. King Chiro. Practice Clinic</i> (1977); limit on damage awards struck down in <i>Sofie v. Fibreboard Corporation</i> (1989)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules	Attorneys' Fees	Case History
West Virginia	\$55.7B.4 (1986) 2 years from injury or reasonable discovery, whichever occurs last; in no event longer than 10 years after injury; minors under 10: 2 years from injury or by age 12, whichever provides a longer period; statute tolled for any period during which fraud or concealment prevents discovery	\$55.7B.9 (1986) \$1 million cap on non-economic damages; court must instruct jury				\$55.75.7 (1986) Expert witness must be licensed physician and engaged in the same or substantially similar medical field as defendant		West Virginia Supreme Court upheld constitutionality of limit on damage awards in <i>Robinson v. Chaleson Area Medical Center</i> (1991)
Wisconsin	\$893.55, 56 (1979) 3 years from injury or 1 year from discovery, but not more than 5 years from act; foreign object: 1 year from discovery or 3 years from act, whichever is later; minors: by age 10 or standard provision, whichever is later	\$893.55(4)(d) (1995) For acts as of May 25, 1995, \$350,000 cap adjusted annually for inflation for non-economic damages, excluding wrongful death cases, which are limited to \$500,000 for a child and \$350,000 for an adult	\$893.55(7) Effective May 25, 1995, collateral source information is admissible at trial	\$655.015 (1986, 1995) For settlement or judgement for act occurring on or after May 25, 1995 in excess of \$100,000, award paid into interest bearing fund, from which periodic payments are made	\$655.42, 442-5 (1985, 1989) Voluntary submission of medical injury claims to mediation panel; findings of panel inadmissible at subsequent court action		\$655.013 (1986) Sliding scale may not exceed: third of first \$1 million or 25% or first \$1 million recovered if liability is stipulated within 180 days, and not later than 60 days before the first day of trial and 20% of any amount exceeding \$1 million	The Wisconsin Supreme Court upheld the constitutionality of earlier statute of limitation in <i>Rod v. Farrell</i> (1980); earlier cap on non-economic damages ruled unconstitutional in <i>Jelenik v. The Saint Paul Fire and Casualty Insurance Company</i> (1994); periodic payment awards upheld in <i>State ex re. Strykowski v. Wilkie</i> (1978)

States	Statute of Limitations	Limits on Damage Awards	Collateral Source Rules	Periodic Award Payments	Pretrial Screening	Expert Witness Rules ¹	Attorneys' Fees	Case History
Wyoming	\$1.3.107, 1.38.102 (1977) 2 years from injury or reasonable discovery; minors: until age 8 or within 2 years, whichever is later; legal disability: 1 year from removal; wrongful death: 2 years from death	Limits on damage awards prohibited by state constitution					Ct. Rules, Contingent Fee R. 5 (1997) Where recover is \$1 million or less: third if claim settled prior 60 days after filing, or 40% if settled after 60 days or judgement; 30% over \$1 million	Wyoming Supreme Court struck down the 1986 pretrial screening panel statute requiring mandatory submission of all medical injury claims to a "medical review panel" in <i>Hoem v. Wyoming</i> (1988)

Sources: National Conference of State Legislatures (October 16, 2002)

McCullough, Campbell and Lane, *Summary of United State Medical Malpractice Law*, available on the Web at <http://www.mcandl.com/states.html>
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Appendix E

State Laws Chart I: Liability Reforms

American Medical Association

Advocacy Resource Center

June 17, 2003

State Laws Chart I: Liability Reforms

State	Damage Caps	Joint Liability Reform	Collateral Source Reform	Attorney Fees Limited	Periodic Payments Permitted
Alabama	None	No. Each defendant is jointly and severally liable.	Yes	No	Yes for awards of future damages in excess of \$150,000.
Alaska	\$400,000 cap on noneconomic damages, or \$8000 multiplied by the injured party's life expectancy, whichever is greater. For severe medical impairment/ disfigurement, limits are the greater of \$1 million or life expectancy multiplied by \$25,000.	Yes. Defendants are responsible only for their proportionate share of negligence.	Yes, after the fact-finder has rendered an award, and not including evidence of benefits received from a federal program that must subrogate, or death benefits paid under a life insurance policy.	No	Yes.
Arizona	None - Constitution prohibits limiting recoverable damages	Yes. Defendants are responsible only for their proportionate share of negligence, except where co-defendants act in concert or a person is an agent or servant of a party.	Yes, discretionary. Defendant may submit evidence of collateral sources of payment and claimant may submit evidence of amount paid to secure benefits.	No, but at the request of any party the court shall review the reasonableness of each party's attorney's fees.	Yes. Any party may elect, and judge must order. Found unconstitutional <i>Smith v. Myers</i> , 191 Ariz. 11, 887 P.2d 541 (1994)
Arkansas	None	No. Each defendant is jointly and severally liable.	No	No	Yes, discretionary for future damages in excess of \$100,000
California	\$250,000 cap on noneconomic damages	Yes. Defendants are proportionately liable for non-economic damages. However, they are jointly and severally liable for economic damages.	Yes. Defendant may introduce evidence of collateral sources of payment, claimant may introduce evidence of amount paid to secure benefits.	Yes, limited to 40% of the first \$50,000; 33 1/3% of the next \$50,000; 25% of the next \$500,000; and 15% of any amount exceeding \$600,000.	Yes. Any party may elect in cases where damages exceed \$50,000.

State Laws Chart I: Liability Reforms

State	Damage Caps	Joint Liability Reform	Collateral Source Reform	Attorney Fees Limited	Periodic Payments Permitted
Colorado	\$250,000 cap on noneconomic damages. Courts may increase the non-economic damages to \$500,000 for future medical expenses and future earnings upon clear justification for doing so. \$1,000,000 cap on total damages. Separate \$250,000 limit on derivative noneconomic damages (nonpecuniary harm to person other than person suffering from direct injury or loss). Caps on damages are adjusted annually for inflation since 1998.	Yes. Defendants are responsible only for their proportionate share of negligence unless persons have consciously conspired and deliberately pursued a common plan or design to commit a tortious act.	Yes, benefits from collateral sources must be disclosed and used to reduce recoverable economic damages, minus any amount paid by the claimant to secure the benefit.	No	Yes. Mandatory for awards of future damages greater than \$150,000. Discretionary for damage awards \$150,000 or less.
Connecticut	None	Yes. Defendants are responsible only for their proportionate share of negligence. However, if within one year after the final judgment the court determines that all or part of a defendant's proportionate share is uncollectible, it shall reallocate the uncollectible noneconomic damages among other defendants according to their percentages of negligence. The court may not reallocate to any such defendant an amount greater than that defendant's percentage of negligence multiplied by such uncollectible amount.	Yes, benefits from collateral sources must be disclosed and used to reduce recoverable economic damages, minus any amount paid by the claimant to secure the benefit.	Yes, limited to 33 1/3% of the first \$300,000; 25% of the next \$300,000, 20% of the next \$300,000, 15% of the next \$300,000, and 10% of amounts exceeding \$1.2 million.	For damages exceeding \$200,000, the court shall give the parties 60 days to negotiate an agreement on method of payment, either in lump sum, periodic payments, or a combination thereof. If they cannot agree, the judge must order payment in a lump sum.

State Laws Chart I: Liability Reforms

State	Damage Caps	Joint Liability Reform	Collateral Source Reform	Attorney Fees Limited	Periodic Payments Permitted
Delaware	None	No. Each defendant is jointly and severally liable.	Yes, the defendant may offer evidence of certain public collateral sources. These sources may not include life insurance or private collateral sources.	Yes, fees are limited to 35% of the first \$100,000, 25% of the next \$100,000, and 10% of any remaining award.	Yes, courts may order periodic payment.
D.C.	None	No. Each defendant is jointly and severally liable.	No	No	Yes, but courts are not required to award payments periodically.
Florida	None, if neither party requests arbitration or the defendant refuses to arbitrate. If the plaintiff refuses, economic and noneconomic damages are capped at \$350,000. If the parties arbitrate, noneconomic damages are capped at \$250,000.	Joint and several liability does not apply to non-economic damages. Joint and several liability applies to part of the economic damages awarded, based on the claimant's percentage of fault and the particular defendant's percentage of fault.	Yes, and the court must reduce damages by the amounts paid to the claimant from collateral sources. If a right of subrogation exists, there is no reduction in damages. Benefits received by the government sources are not considered collateral benefits.	Yes. Levels vary based on how far the proceedings go before payment is received (settled, litigated, etc.)	Yes, for future economic awards exceeding \$250,000, the court must order periodic payments at the request of any party unless the court determines that manifest injustice would result to any party.
Georgia	\$250,000 cap on punitive damages	Defendants can be held jointly and severally liable for non-economic and economic damages if the claimant is without fault. If the plaintiff is to some degree responsible for the injury or damages claimed, the trier of fact may apportion damages among the persons who are liable and whose degree of fault is greater than the claimants, based on the degree of fault of each person. In this case, the parties shall not be held jointly liable.	No	No	No

State Laws Chart 1: Liability Reforms

State	Damage Caps	Joint Liability Reform	Collateral Source Reform	Attorney Fees Limited	Periodic Payments Permitted
Hawaii	\$375,000 cap on noneconomic damages, with exceptions for certain types of damages, ie. mental anguish	Yes. Defendants are responsible only for their proportionate share of negligence, with the following exceptions: recovery of economic damages in actions involving injury or death, and noneconomic damages in such actions, where a tortfeasor's negligence is 25% or more; intentional torts; strict liability torts; and product liability torts.	No	In all tort actions, fees shall be limited to a reasonable amount as approved by the court.	No
Idaho	\$250,000 cap on noneconomic damages per claimant in all personal injury and wrongful death actions. Cap will be adjusted annually beginning on July 1, 2004 based on the average state wage increase. Cap does not apply to willful or reckless conduct or felonious acts.	Yes. Defendants are responsible only for their proportionate share of negligence, except where co-defendants were acting in concert or a person is an agent or servant of a party.	Yes, collateral sources may be submitted to the judge following the verdict. Judgments may be entered only for amounts that exceed recovery from collateral sources.	No	Yes, upon the request of either party, at the discretion of the court, and only in P1 cases, where damages exceed \$100,000. May not be ordered for intentional torts, gross negligence or an extreme deviation from reasonable standard of conduct.
Illinois	None	No. Each defendant is jointly and severally liable.	Yes, applicable only to medical malpractice claims. A judgment will be offset by 50% of lost wages and 100% of medical benefits received, minus any amount paid by the claimant to secure such benefits. The total judgment may not be reduced more than 50%. Does not apply to benefits that are subject to subrogation.	Yes. Fees are limited to 33 1/3% of the first \$150,000; 25% of the next \$850,000; and 20% of amounts over \$1 million. Attorney may petition court for additional fees.	Party must elect periodic payment of damages at least 60 days prior to commencement of trial unless leave of court is obtained. Election is accepted if both parties agree or the other party does not make an objection to the election of periodic payments, or future damages will exceed \$250,000.

State Laws Chart I: Liability Reforms

State	Damage Caps	Joint Liability Reform	Collateral Source Reform	Attorney Fees Limited	Periodic Payments Permitted
Indiana	\$750,000 cap on total damages for any act of malpractice that occurs after 12/31/89 and before 7/1/99. \$1.25 million total cap for any act of malpractice that occurs after 6/30/99. Health care providers are not liable for more than \$250,000 for an occurrence of malpractice. Any amount awarded in excess of \$250,000 will be paid through the Patient Compensation Fund.	No. Each defendant is jointly and severally liable.	Yes, trier of fact shall consider collateral sources of payment when determining award and court shall consider when reviewing awards that are allegedly excessive. Evidence of life insurance or other death benefits; benefits paid by claimant or family; or payments made by state or U.S. prior to trial shall not be considered collateral sources of payment.	Yes. Attorney may collect only 15% of damages awarded under Patient Compensation Fund.	Yes. Law permits, but does not require.
Iowa	None	Yes. Defendants are responsible only for their proportionate share of negligence where a defendant is found to bear less than 50% of the total fault. If a defendant is 50% or more liable, he is jointly and severally liable for economic damages only.	Yes, and damages must be reduced by the amount received from collateral sources.	No, but courts determine reasonableness of fee arrangements.	Yes. Any party may request periodic/structured payment. Court determines the reasonableness.
Kansas	\$250,000 cap on noneconomic damages	Yes. Defendants are responsible only for their proportionate share of negligence.	No.	No	Not mandated
Kentucky	None	Jury may either apportion damages among defendants or hold defendants jointly and severally liable.	No	No	Not mandated
Louisiana	\$500,000 cap on total damages, excluding damages recoverable for future medical care	Yes. Defendants are responsible only for their proportionate share of negligence.	No	No	Yes, for amounts paid by the state from the Patient Compensation Fund.

State Laws Chart I: Liability Reforms

State	Damage Caps	Joint Liability Reform	Collateral Source Reform	Attorney Fees Limited	Periodic Payments Permitted
Maine	\$400,000 cap on noneconomic damages in wrongful death actions	No. Each defendant is jointly and severally liable.	Yes. Evidence is admissible after a verdict has been rendered, and the judgment must be reduced by the amount received from collateral sources.	Yes. Fees are limited to 33 1/3% of the first \$100,000; 25% of the next \$100,000; and 20% of amounts over \$200,000.	Yes. If damages exceed \$250,000, either party may request periodic payment.
Maryland	\$500,000 cap on noneconomic damages on action for personal injury or wrongful death, increased by \$15,000 annually beginning 10/1/95. In wrongful death actions with two or more claimants or beneficiaries, an award of noneconomic damages may be up to 150% of the limit.	No. Each defendant is jointly and severally liable.	No	No	Yes. Courts and arbitrators may order periodic payment.
Massachusetts	\$500,000 cap on noneconomic damages, with exceptions for proof of substantial disfigurement or permanent loss or impairment, or other special circumstances which warrant a finding that imposition of such limitation would deprive the plaintiff of just compensation for the injuries sustained.	No. Each defendant is jointly and severally liable.	Yes, benefits from collateral sources must be disclosed and used to reduce recoverable economic damages, minus any amount paid by the claimant to secure the benefit.	Yes. Fees are limited to 40% of the first \$150,000; 33 1/3% of the next \$150,000 and 30% of the next \$200,000; and 25% of amounts exceeding \$500,000. An attorney may not take an amount that would leave the claimant with less than the amount of unpaid past and future medical expenses, with exceptions.	No

State Laws Chart I: Liability Reforms

State	Damage Caps	Joint Liability Reform	Collateral Source Reform	Attorney Fees Limited	Periodic Payments Permitted
Michigan	\$280,000 cap on noneconomic damages, adjusted annually for inflation, except in cases where the plaintiff is hemiplegic, paraplegic, or quadriplegic due to an injury to the brain or spinal cord, or where the plaintiff has permanently impaired cognitive capacity, or the plaintiff has had a permanent loss of or damage to a reproductive organ, then noneconomic damages shall not exceed \$500,000.	No. Each defendant is jointly and severally liable.	Yes, benefits from collateral sources must be disclosed and used to reduce recoverable economic damages, minus any amount paid by the claimant to secure the benefit.	Rules limit contingency fees to one third of total compensation.	No
Minnesota	None	No. Each defendant is jointly and severally liable, except a defendant whose fault is 15% or less is jointly liable for no more than 4 times his percentage of fault.	Yes, within 10 days of the verdict and upon motion of a party. In such cases, the court must reduce the award by the amount received from collateral sources. Such reduction shall be offset by any amount paid by the plaintiff to secure the award.	No	Yes. Court must hold hearing in cases where future damages exceed \$100,000 to allow the claimant to consider if damages should be paid periodically.
Mississippi	\$500,000 cap on noneconomic damages except in cases where the patient suffers disfigurement or if the judge determines punitive damages are warranted. Cap will be adjusted to \$750,000 for causes of action filed after 7/1/2011 and to \$1 million for causes of action filed after 7/1/2017.	Partially. For noneconomic damages, defendants are responsible only for their proportionate share of negligence. For economic damages, a joint tortfeasor who is less than 30% at fault is liable only for his proportionate share of damages, a joint tortfeasor who is more than 30% at fault can be held liable for up to 50% of the economic damages.	No	No	Yes, but they are not mandated.

State Laws Chart I: Liability Reforms

State	Damage Caps	Joint Liability Reform	Collateral Source Reform	Attorney Fees Limited	Periodic Payments Permitted
Missouri	\$350,000 cap on noneconomic damages, adjusted annually for inflation	No. Each defendant is jointly and severally liable, but a defendant is jointly liable only with defendants whose percentage of fault is equal to or less than his own.	No	No	Yes. In cases where payment for future damages exceeds \$100,000, court may order periodic payment upon request of either party. Court has upheld the constitutionality of this law.
Montana	\$250,000 cap on noneconomic damages	Any party whose negligence is 50% or less of the combined negligence of all persons is severally liable only. The remaining parties are jointly and severally liable for the total less the amount attributable to the claimant. A party may be jointly liable for all damages caused by the negligence of another if both acted in concert or if one party acted as an agent of the other.	Yes, in cases where damages exceed \$50,000. Total amount of prior payment from collateral sources that do not involve rights of subrogation.	No	Yes. Upon any party's request, the court must enter an order for periodic payment of future damages exceeding \$50,000.
Nebraska	\$1.25 million in total damages. Health care providers who qualify under the Hospital-Medical Liability Act (i.e. carry minimum levels of liability insurance and pay surcharge into excess coverage fund) shall not be liable for more than \$200,000 in total damages. Any excess damages shall be paid from the excess coverage fund.	Yes. Defendants are responsible only for their proportionate share of negligence, except where parties have acted in concert and caused harm as part of a common enterprise or plan.	Yes. The court shall determine in a separate hearing the amount of any credit against a claimant's damages based on any non-refundable insurance benefits reimbursed to the claimant. This information, however, is not admissible as evidence.	No, but upon motion of either party, the court must review and determine reasonableness of fees.	No

State Laws Chart I: Liability Reforms

State	Damage Caps	Joint Liability Reform	Collateral Source Reform	Attorney Fees Limited	Periodic Payments Permitted
Nevada	\$350,000 cap on noneconomic damages awarded to each plaintiff from each defendant except when: (1) the defendant's conduct constitutes gross malpractice, or (2) the court determines by clear and convincing evidence that a higher award is justified because of exceptional circumstances.	Yes. Defendants are responsible only for their proportionate share of negligence. Joint and several still applies to economic damages.	Yes. The judge must reduce the verdict by the amount of any collateral benefits, except where a right of subrogation exists.	No	Yes, if requested by the claimant.
New Hampshire	None	Yes	No. Supreme Court has held abolition of the rule unconstitutional.	The court must approve fees for actions resulting in settlement/judgment of \$200,000 or more. Specific limits for medical cases have been ruled unconstitutional.	Yes. The court has authority to order periodic payments. Specific requirements for medical cases have been ruled unconstitutional.
New Jersey	Punitive damages limited to the greater of \$350,000 or five times compensatory damages.	Yes. Defendants are responsible only for their proportionate share of negligence if they are found to be less than 60% at fault. Defendants found to be 60% at fault are subject to a modified rule.	Yes. Collateral source payments must be disclosed and deducted from claimant's damages	Yes. Fees may not exceed the following: 33 1/3% of the first \$500,000; 30% of the next \$500,000; 25% of the next \$500,000; 20% of the next \$500,000; and an amount the court deems reasonable for fees over \$2 million.	No

State Laws Chart I: Liability Reforms

State	Damage Caps	Joint Liability Reform	Collateral Source Reform	Attorney Fees Limited	Periodic Payments Permitted
New Mexico	\$600,000 cap on total damages, excluding punitive damages and past and future medical care. Health care providers personal liability shall not exceed \$200,000, including payments for future medical expenses. Any award in excess of this amount shall be paid by the patient compensation fund.	Yes. Defendants are responsible only for their proportionate share of negligence except in cases where defendant intended to inflict injury, strict liability, vicarious liability or situations "having a sound basis in public policy."	No	No	Yes. Future medical expenses are paid as they are incurred by claimant.
New York	None	Yes for non-economic damages. Defendants are responsible only for their proportionate share of negligence if they are found to be 50% or less liable. Defendants can be held jointly and severally liable for economic damages.	Yes. Collateral sources of payment are admissible as evidence and must reduce the award by the amount recovered. Such reduction shall be offset by premiums paid by the claimant for the benefit for two years preceeding the action and projected future costs of maintaining benefits.	Yes. Fees are capped as follows: 30% of the first \$250,000; 25% of the next \$250,000; 20% of the next \$500,000; 15% of the next \$250,000; and 10% of fees of \$1.25 million or more.	Yes. Future damages over \$250,000 must be paid periodically.
North Carolina	None	No. Each defendant is jointly and severally liable.	No	No	No
North Dakota	\$500,000 cap on noneconomic damages. Economic damage awards in excess of \$250,000 are subject to judicial review for reasonableness.	Yes. Defendants are responsible only for their proportionate share of negligence except where defendants act in concert in committing, aiding and encouraging, or ratifying or adopting a tortious act.	Yes. Defendant may apply to the court for a reduction of economic damages based on collateral sources of payment.	No	Yes. In cases where future economic damages will be awarded for continuing institutional/custodial care lasting more than two years, a party may request periodic payments. Court has discretion to grant.

State Laws Chart I: Liability Reforms

State	Damage Caps	Joint Liability Reform	Collateral Source Reform	Attorney Fees Limited	Periodic Payments Permitted
Ohio	Cap on noneconomic damages of the greater of \$250,000 or three times economic damages up to a maximum of \$350,000 per plaintiff or 500,000 if there are multiple plaintiffs. For catastrophic injuries the maximum may increase to \$500,000 per plaintiff or \$1 million for multiple plaintiffs.	Yes. Defendants are responsible for their proportionate share of negligence for noneconomic damages. For economic damages, defendants who are 50% or less at fault are responsible for their proportionate share of negligence, but defendants who are held more than 50% at fault are jointly and severally liable. No. Each party is jointly and severally liable. However, case law has held that several liability exists where a claimant is held partially responsible for a tortious act.	Yes. Defendants may introduce evidence of collateral sources of payments made to plaintiffs. The plaintiff may submit evidence of any amount the plaintiff has paid or contributed to secure the benefits.	No, but their fees are subject to approval by the probate court if their fees exceed the noneconomic damages awarded.	Yes. Court may award periodic payment of damages for awards that exceed \$50,000 if the plaintiff or defendant files a motion with the court.
Oklahoma	Punitive damages for cases where the defendant acted with reckless disregard are limited to the greater of \$100,000 or the amount of actual damages awarded. No limit on punitive damages for cases where the defendant acted intentionally and with malice.	Yes. Defendants are responsible only for their proportionate share of negligence, but if within one year after the final judgment the court determines that all or part of a defendant's proportionate share is uncollectible, it shall reallocate the uncollectible noneconomic damages among other defendants according to their percentages of negligence.	No	Yes. In contingency fee arrangements, attorney may not contract to receive more than 50% of the recovery.	No
Oregon	None – Constitution prohibits caps on noneconomic damages	Yes. Defendants are responsible only for their proportionate share of negligence, but if within one year after the final judgment the court determines that all or part of a defendant's proportionate share is uncollectible, it shall reallocate the uncollectible noneconomic damages among other defendants according to their percentages of negligence.	Yes, but no deduction can be made for life insurance, benefits for which the claimant has paid, retirement/disability, social security, or insurance benefits for which the person injured or deceased paid premiums.	Partially. Attorney fees recovered from an award for punitive damages are limited to 20% of the 40% paid to the prevailing party. No limit on attorney fees for economic or noneconomic damages.	No

State Laws Chart I: Liability Reforms

State	Damage Caps	Joint Liability Reform	Collateral Source Reform	Attorney Fees Limited	Periodic Payments Permitted
Pennsylvania	Constitution prohibits caps on non-economic damages. Punitive damages are capped at 2 times actual damages.	Yes. Liability for each defendant shall be he several only and not joint. Unless, the defendant's percentage of liability is 60% or greater then the defendant can be held jointly and severally liable.	Yes. Awards are reduced by the amount paid to the claimant from other sources.	No.	Yes for future economic damages that exceed \$100,000, unless the claimant objects.
Rhode Island	None	No. Each party is jointly and severally liable.	Yes. Collateral payment sources may be introduced and claimant may introduce evidence of any payments made to secure such benefit. Award must be reduced by the difference between the collateral payments received and payments made by the plaintiff to secure such benefits.	No	Not mandated, but parties must consider if damages exceed \$150,000.
South Carolina	None	No. Each party is jointly and severally liable.	No	No	No
South Dakota	\$500,000 cap on total general damages	No. Each party is jointly and severally liable, but parties who are allocated less than 50% of the total fault may only be jointly liable for more than 2xs the percentage of fault allocated to that party.	Yes, but no evidence of payments subject to subrogation and not purchased by the claimant or paid by the government.	No	Yes. If a party makes an effective election and both parties agree or a timely objection is not filed, or if a timely objection is filed but the claimant can prove future damages are in excess of \$200,000.
Tennessee	None	Yes. Courts have held joint and several liability obsolete.	Yes. Damages awarded will be reduced by collateral sources of payment. Such reduction shall be offset by the amount paid by the claimant to secure the benefit.	Yes. Attorney compensation shall be awarded by the court, but may not exceed 33 1/3% of total damages.	No

State Laws Chart I: Liability Reforms

State	Damage Caps	Joint Liability Reform	Collateral Source Reform	Attorney Fees Limited	Periodic Payments Permitted
Texas	\$500,000 cap on all damages for wrongful death, indexed for inflation since 1977. In 2002 the cap reached approximately \$1.4 million.	Yes. Defendants are responsible only for their proportionate share of negligence, unless the percentage of responsibility attributed to the defendant is greater than 50%.	No	No	No
Utah	\$250,000 cap on noneconomic damages, indexed for inflation. For causes of action arising on or after 7/1/2001 but before 7/1/02 limit increased to \$400,000. Limit adjusted annually for inflation thereafter.	Yes. Defendants are responsible only for their proportionate share of negligence.	Yes. Court must reduce damages by any collateral sources of payment received by the claimant, except for benefits from payors with subrogation rights. Reduction shall be offset by amount paid by claimant to secure such benefits.	Yes. Total compensation may not exceed 1/3 of total damages.	Yes. Any party may request periodic payments, and the court must order such payments if future damages exceed \$100,000.
Vermont	None	No. Each party is jointly and severally liable.	No	No	No
Virginia	\$1.5 million cap on total damages for acts occurring on or after Aug. 1, 1999. This cap is increased by \$50,000 annually until 2007. In 2007 and 2008, the cap is increased by \$75,000.	No. Each party is jointly and severally liable.	No	No	Yes, but no requirement exists for such payments in PI cases.
Washington	None	If the claimant is at fault, defendants are responsible only for their proportionate share of negligence, except where parties act in concert or where a person was acting as an agent or servant of the party. If the claimant is not at fault, defendants are jointly and severally liable.	Yes. Evidence may be presented, except that evidence of payments from insurance policies purchased with personal or family assets or by an employer on behalf of an employee may not be introduced.	Court shall determine the reasonableness of each party's attorneys' fees.	Yes. Any party may request periodic payments, and the court must order such payments if future economic damages exceed \$100,000.

State Laws Chart 1: Liability Reforms

State	Damage Caps	Joint Liability Reform	Collateral Source Reform	Attorney Fees Limited	Periodic Payments Permitted
West Virginia	\$250,000 cap on noneconomic damages per occurrence. \$500,000 cap on noneconomic damages for cases involving (1) wrongful death, (2) permanent and substantial physical deformity, loss of use of limb or loss of a bodily organ system, or (3) permanent physical or mental functional injury that permanently prevents the injured person from being able to independently care for himself or herself and perform life sustaining activities. Adjusted annually for inflation, but the \$250,000 cap shall not exceed \$375,000 and the \$500,000 cap shall not exceed \$750,000.	Yes. Defendants are responsible only for their proportionate share of negligence.	Yes. The defendant may introduce evidence of collateral sources and the plaintiff may introduce evidence of payments made to secure such benefits. The court must reduce the award by the amount the plaintiff recovered from collateral sources offset by any payments or contributions made to secure such benefits.	No	No
Wisconsin	\$350,000 cap on noneconomic damages for medical malpractice claims, adjusted annually for inflation. For wrongful death actions, \$350,000 cap on noneconomic damages for adults, and \$500,000 cap on noneconomic damages for minors.	Yes. Defendants are responsible only for their proportionate share of negligence if they are less than 51% at fault unless a defendant acted as part of a common scheme or plan.	Yes. The defendant may introduce evidence of payments received from collateral sources.	Yes, as follows: 33 1/3% of the first \$1 million, or 25% if certain procedural timeframes are met; 20% of amounts exceeding \$1 million. Court has discretion to increase fees.	Yes, if future medical expenses are expected to exceed \$100,000.

State Laws Chart I: Liability Reforms

State	Damage Caps	Joint Liability Reform	Collateral Source Reform	Attorney Fees Limited	Periodic Payments Permitted
Wyoming	None - Constitution prohibits caps	Yes. Defendants are responsible only for their proportionate share of negligence.	No	Yes, when recovery is \$1 million or less as follows; 33 1/3% if claim is settled prior to or within 60 days after filing; 40% if claim is settled more than 60 days after filing or upon judgment. If recovery is more than \$1 million, 30% of recovery in excess of \$1 million is considered reasonable.	Not mandated

Appendix F

Summary of California Proposition 103
California Department of Insurance
2003

PROVISIONS OF CALIFORNIA PROPOSITION 103
AFFECTING THE RATE REGULATION DIVISION, CALIFORNIA DEPARTMENT OF
INSURANCE Source: California Department of Insurance, Rate Regulation Division.

Regulation Prior to Proposition 103: Prior to the passage of Proposition 103 on November 8, 1988, the California Department of Insurance operated under the McBride-Grunsky Insurance Regulatory Act. Under this Act, insurance companies were not required to file rates for approval except for health and life. California was considered an "open competition" state in which competition regulated the marketplace. The Consumer Services Division was responsible for monitoring insurance companies' rating practices. On December 16, 1988, Rate Filing Bureaus were created in the Rate Regulation Division (RRD) to implement the following provisions of Proposition 103.

Rollback Provision: Proposition 103 required that every insurer reduce its rates to at least 20% less than the rates that were in effect on November 8, 1987 unless such rollback would lead to a company's insolvency. This provision was later changed by the California Supreme Court to allow companies a fair rate of return. Since 1989, the RRD has been responsible for negotiating with insurance companies to meet their rollback obligations.

Personal Automobile Rating Factors: Another major provision of Proposition 103 dealt with personal automobile insurance. In Section 1861.02 (a) of the CIC, personal automobile insurance rates must be determined using the following factors in decreasing order of importance--insured's driving safety record, number of miles driven annually by the insured, and number of years of driving experience the insured has had. In addition, the commissioner could specify other rating factors that have a substantial relationship to the risk of loss. As such, the RRD required insurance companies to submit automobile classification plans which complied with these codes and emergency regulations. Permanent regulations are being developed.

Good Driver Discount Provision: Proposition 103 also stated that an insurer could not refuse to write an applicant that qualifies for a good driver discount. Further, the good driver discount should be at least 20% below the rate the insured would otherwise have been charged for the same coverage. Proposition 103 indicated that a person qualifies for a good driver discount if s/he meets all of the following criteria--licensed to drive a motor vehicle for the previous three years, has not had more than one violation point during the previous three years, and was not a driver of a motor vehicle involved in an accident which resulted in death or in total loss or damage exceeding \$500, and was principally at fault. Accordingly, the RRD reviews companies' automobile classification plans and individual insurance policies to ensure these provisions are followed by insurance companies.

Prior Approval of Filings: Beginning November 8, 1989, property and casualty insurance rates must be approved by the insurance commissioner prior to use. As the Code continues to state that every insurer desiring to change any rate must complete a rate application with the commissioner, the RRD established a rate application that companies must complete if they wish to make any adjustments to their rates. Such rate applications are reviewed for acceptability by the Rate Filing Bureaus within the RRD. Weekly, a list of filings that have received approval letters is issued by Rate Regulation.

Public Notice: Section 1861.05 (c) of CIC indicates that public notice must be given for all rate applications. To meet this public notice requirement, the RRD issues a public notice every Friday of prior approval rate filings and file and use filings that have been received and meet basic compliance. The Rate Enforcement Bureau of the California Department of Insurance will send a copy of the public notice to any person or business free of charge.

Deemer Provision: Proposition 103 also stated that an application is deemed approved sixty days after public notice is given unless: (1) a consumer or consumer group requests a hearing within forty-five days of public notice and the commissioner grants the hearing or determines not to grant the hearing and issues written findings in support of that decision, (2) the commissioner on his own motion determines to hold a hearing, or (3) the proposed rate adjustment exceeds 7% of the then applicable rate for personal lines or 15% for commercial lines, in which case the commissioner must hold a hearing upon a timely request. The RRD reviews rate filings within these provisions and timeframes.

Public Viewing Rooms: As Proposition 103 states that all rating information provided to the commissioner must be available for public inspection, the RRD maintains public viewing rooms in San Francisco and Los Angeles.

Advisory Organizations: Although Proposition 103 eliminated rating organizations in California, advisory organizations may still exist. Advisory organizations file loss costs and forms with the RRD.

Lines Regulated by Proposition 103: Overall the following lines of insurance are regulated by Proposition 103: Personal automobile, dwelling fire, earthquake, homeowners, inland marine, and umbrella; Commercial aircraft, automobile, boiler and machinery, burglary and theft, businessowners, earthquake, farmowners, some fidelity, fire, glass, inland marine, medical malpractice, miscellaneous, multi-peril, other liability, professional liability, special multi-peril, umbrella, and coverage under the United States Longshoremen's & Harbor Workers' Compensation Act.

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